

283082

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JR. JONES			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 28, 1985		2b. HOUR 10:45AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 20 1920		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) + CONTROLLER		12b. KIND OF BUSINESS OR INDUSTRY WIRE & CABLE				
13a. STATE PA.		13b. CITY OR TOWN YORK		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HUMPHREY JONES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL KELBAUGH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W.W. II 220-01-2176		17. INFORMANT MARJORIE JONES 2985 DEARBORN LA. YORK, PA.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>3 mos</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>disseminated intravascular coagulopathy</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> , 19 <u>85</u> , to <u>9/28</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/28</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>AMY KLION</u>		DEGREE		22c. DATE SIGNED 9/28		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMY KLION		22e. ADDRESS Johns Hopkins Hosp				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/2/1985		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		
24. FUNERAL DIRECTOR NAME David E. Small		ADDRESS 471 MADISON AV. YORK, PA.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		
25a. DATE REC'D. BY REGISTRAR OCT. 03 1985		25b. REGISTRAR'S SIGNATURE <u>John E. Anderson</u>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove columnar Pages 1 and 2 should be filed with the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified also.

BP 999/999
DHMH: 16 60M 7/84
(VRA 15. 4)



20% CO. DIRECT

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277057

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 5 1 7 1

1. FOR William T. Jones
STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Thomas JONES			2a. DATE OF DEATH MONTH DAY YEAR 9 28 85		2b. HOUR 10:31 M
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 10 3 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP.		12a. USUAL OCCUPATION (TYPE THE WORK FOR MOST OF WORKING LIFE) Furniture Finisher		12b. KIND OF BUSINESS OR INDUSTRY Furniture
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE M.D. 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 101 Hammonds Lane 21225
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Brown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 248-10-8707		17. INFORMANT ADDRESS Mary A. Hammock Same as 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY ARREST.

DUE TO, OR AS A CONSEQUENCE OF

(b) END STAGE COPD, PNEUMONIA, BRONCHITIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

HEART FAILURE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-21-85, 19, to 9-28, 1985, that (I) (we) last saw the deceased alive on 9-28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MICHAEL KAZAK		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-28-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK		22e. ADDRESS 3001 SO. HANOVER ST.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/1/85	23c. NAME OF CEMETERY OR CREMATORY Cedar Creek Bap. Church	23d. LOCATION CITY OR TOWN COUNTY STATE Bishopville Lee S.G.
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR OCT 1 1985	
		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



269115

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

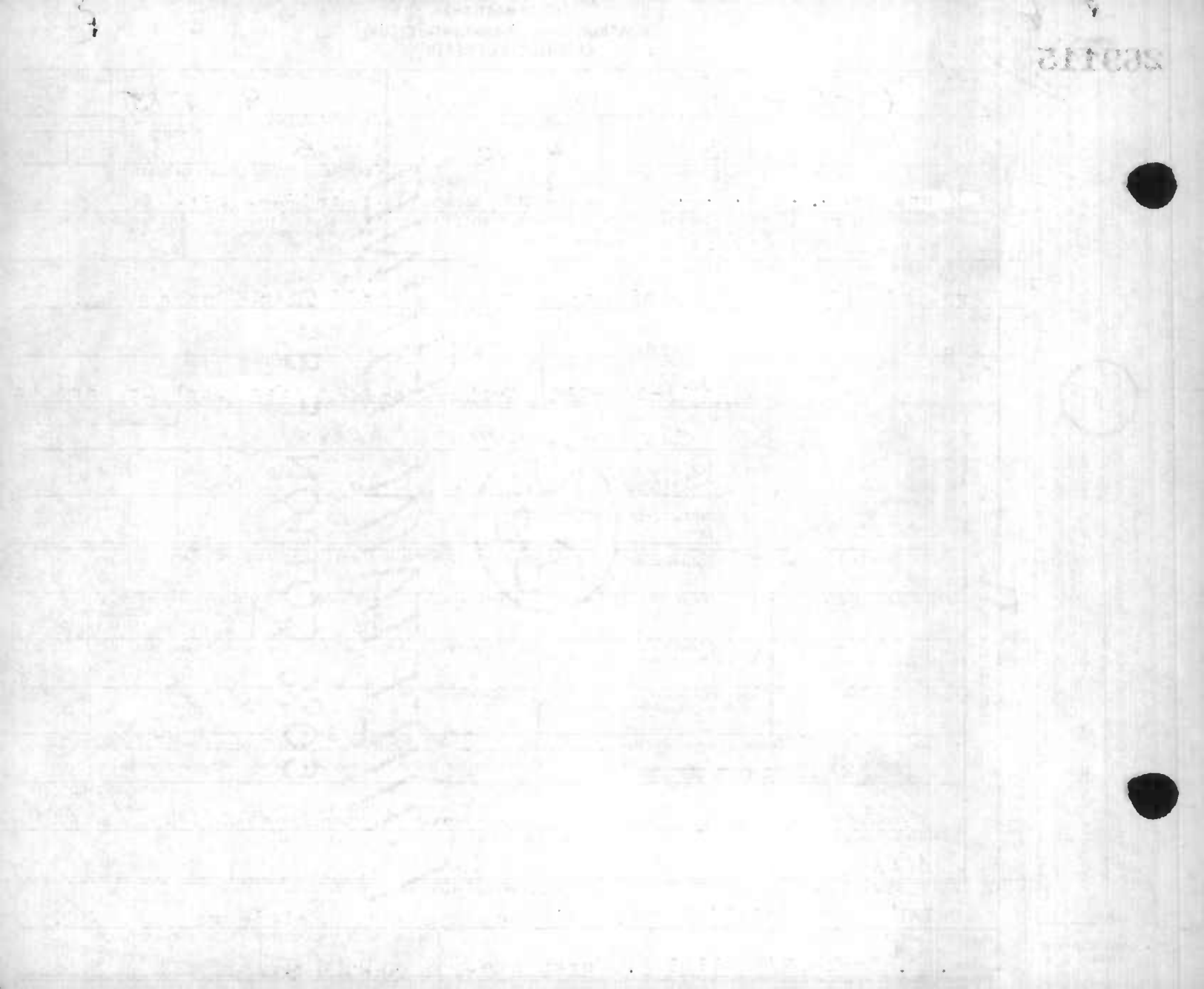
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial/transit permit. Then please remove carbon pages 1 and 2 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) McKinley (JORDON)		FIRST McKinley MIDDLE (JORDON) LAST Jordan (McKinley)		2a. DATE OF DEATH MONTH 9 DAY 19 YEAR 85 2b. HOUR 5:54 PM	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH 4 DAY 10 YEAR 20		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Winnboro S.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, STREET ADDRESS) Francis Scott Key		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Balto 13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 616 Peach Orchard La. 21222	
14. FATHER'S NAME FIRST Daniel MIDDLE Jordan LAST Mattie		15. MOTHER'S MAIDEN NAME FIRST Mattie MIDDLE Jordan LAST Arthur		16. ADDRESS 616 Peach Orchard La.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 251-24-6514		17. INFORMANT Arthur Jordan	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Arrhythmia / Cardiac myopathy DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/19 , 19 85 , to 9/19 , 19 85 , that (I) (we) saw the deceased alive on 9/19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mark Eisner MD		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK EISNER		22e. ADDRESS FSK MC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/25/85		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery Baltimore Md.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North ave.		25a. DATE REC'D. BY REGISTRAR SEP 24 1985 25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson	

BP

SECRET



266068

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25179

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
OLLIE		JORDAN						9-13-85		19						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		2d. HOUR	
male	Black	8 6 1919		67		YRS.				9-13-85		19				6:37P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.	
South Carolina		USA		WIDOWED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		1610 E. Biddle Street		Laborer		none											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1610 E. Biddle St. Md. 21213									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Unknown		Unknown															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		228-32-2390		Martha Corbin		910 Andover Rd. Md. 21218											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 9-14-85

EXAMINER'S NAME (TYPE OR PRINT)

Gregory R. Kauffman, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9-18-85

23c. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

23d. LOCATION CITY OR TOWN

Glen Burnie

COUNTY

A.A.CO.

STATE

MD.

24. FUNERAL DIRECTOR

NAME William J. Spicer 1639 N. Broadway St.

ADDRESS

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

SEP 19 1985

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

SECRET

20X LOTION 4800
MINI-FEELER



20X LOTION 4800

260088

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>PAUL Lee JORDAN, Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 8 85</i>		2b. HOUR <i>11 AM</i>								
3. SEX <i>M</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 26 81</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>3</i>		IF UNDER 1 YEAR MONTHS DAYS <i>3</i>		IF UNDER 74 HRS HOURS MIN <i>11 AM</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MO</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.							
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>DR. WASHINGTON PED. HOSP.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CHELT</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>MD</i>						13b. COUNTY <i>BALT. CITY</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <i>21225 800 BETHUNE</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Paul Lee Jordan</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>DEANNA HARRIS</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>						16b. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT ADDRESS <i>MOTHER 800 BETHUNE CITY</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 MIN</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>SEVERE BRAIN DAMAGE</i>		<i>74 YEARS</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>PREVIOUS CARDIAC ARREST</i>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <i>SEPTEMBER 8, 1985</i> to <i>SEPTEMBER 9, 1985</i> , that (I) last saw the deceased alive on <i>SEPTEMBER 8, 1985</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did) view the body after death.							
22b. SIGNATURE <i>Stephen J. Metz</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>9-8-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STEPHEN J. METZ MD</i>				22e. ADDRESS <i>1708 W. ROVERS, BALT. MD.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9-12-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ba Ho Cem.</i>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>Ba Ho. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Jas. A. MORTON & Sons</i>				ADDRESS <i>1701 Laurens</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 11 1985</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is properly filed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified at once.



261001

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
EVELYN						JUSTICE		AUGUST 26, 1985										11:25A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
Female		White		MONTH DAY YEAR 5 10 10		75 YRS		MONTHS DAYS		HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		U.S.				BALTIMORE CITY												MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Sec'y		Plumbing													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE											
Md.		Somerset		Crisfield		YES <input type="checkbox"/> NO <input type="checkbox"/>		Johnson Creek Rd. 21817											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST Harlan Feaster		FIRST MIDDLE LAST Tillie F. Lowe																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		213-24-4929		Mr. Walter Feaster		Crisfield, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		2.5 hours											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		Sepsis		48 hours													
		DUE TO, OR AS A CONSEQUENCE OF		Perforated Large Bowel And embolus		72 hours													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		Thoracic - Abdominal aneurysm																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
8/20/85		Thoracic - Abdominal aneurysm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
		HOUR A.M. MONTH DAY YEAR P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE									
WIPED <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																			
22a. I certify that (I) (this hospital) attended the deceased from August 20, 1985, to August 26, 1985, that (I) (we) last saw the deceased alive on August 26, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
		MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8/26/85													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
DAVID J. BRIONES		1-DEAUVILLE CT, Pikesville MD 21208																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Removal		8/27/85																	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
NAME		ADDRESS																	
Anatomy Board		Balto., Md.																	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN KAHN			2a. DATE OF DEATH MONTH DAY YEAR 9-12-85			2b. HOUR MIN. 10⁴⁵ P.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10-5-15		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BAITIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ARMACOST NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Read Drug Co.	
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Mears		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 217-05-1410		17. INFORMANT ADDRESS Janet Sander RU - Armacost Nsg. Home					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) **Cardiac Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) **Alzheimers**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS INJURY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-6 19 85 , to 9-12 19 85 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mitchell Wiedefeld				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Mitchell Wiedefeld				23b. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/85		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Baltimore Co., Maryland	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR 212 SEP 18 1985		25b. REGISTRAR'S SIGNATURE John Davidson	



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1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy Kalb			2a. DATE OF DEATH MONTH DAY YEAR SEPT 26 85			2b. HOUR 1010^A		
3. SEX FEMALE	4. RACE CAU	5. DATE OF BIRTH MONTH DAY YEAR 8 28 22		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.				
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		

13a. STATE MD.			13b. COUNTY BALTO	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 833 50th ST. 21222		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Foehrknecht			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA ADDICKS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 219-80-1231		17. INFORMANT ADDRESS George Kalb 833 50th ST.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) sign the body after death.

22b. SIGNATURE Karen Sauter	DEGREE MD	22c. DATE SIGNED 26 Sept 85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAREN SAUTER	22e. ADDRESS Francis Scott Key 4940 Eastern Ave	22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-28-85	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.
24. FUNERAL DIRECTOR NAME ADDRESS Frank D. Bell, Inc 322 S. High St.		25a. DATE REC'D. BY REGISTRAR OCT 2 1985	25b. REGISTRAR'S SIGNATURE Lelia E. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANDREW		FIRST D.		MIDDLE KARAVEDAS		LAST		2a. DATE OF DEATH MONTH SEPTEMBER DAY 29 YEAR 1985		2b. HOUR 1120P M		
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH MONTH 10 DAY 07 YEAR 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 72 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4013 Belwood Ave 21206		
14. FATHER'S NAME FIRST Dionysios MIDDLE Karavedas LAST Fengaras				15. MOTHER'S MAIDEN NAME FIRST Viola MIDDLE Fengaras LAST Fengaras								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-18-9997		17. INFORMANT Mrs Frances R Karavedas				ADDRESS Same As 13e				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF CERVIX & MEDIASTINUM MONTHS DUE TO, OR AS A CONSEQUENCE OF (c) 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (this hospital) attended the deceased from 9/16 , 19 85 , to 9/29 , 19 85 , that (we) last saw the deceased alive on 9/29 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.												
22b. SIGNATURE Steven H. Peterson				DEGREE M.D.				22c. DATE SIGNED 9/30/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN H. PETERSON				22e. ADDRESS ST. ANNE HOSPITAL, 200 S. CAMP AVE.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/2/85		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox		23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE						
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				ADDRESS				25a. DATE REC'D. BY REGISTRAR OCT 1 1985				
								25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, it should be filed in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

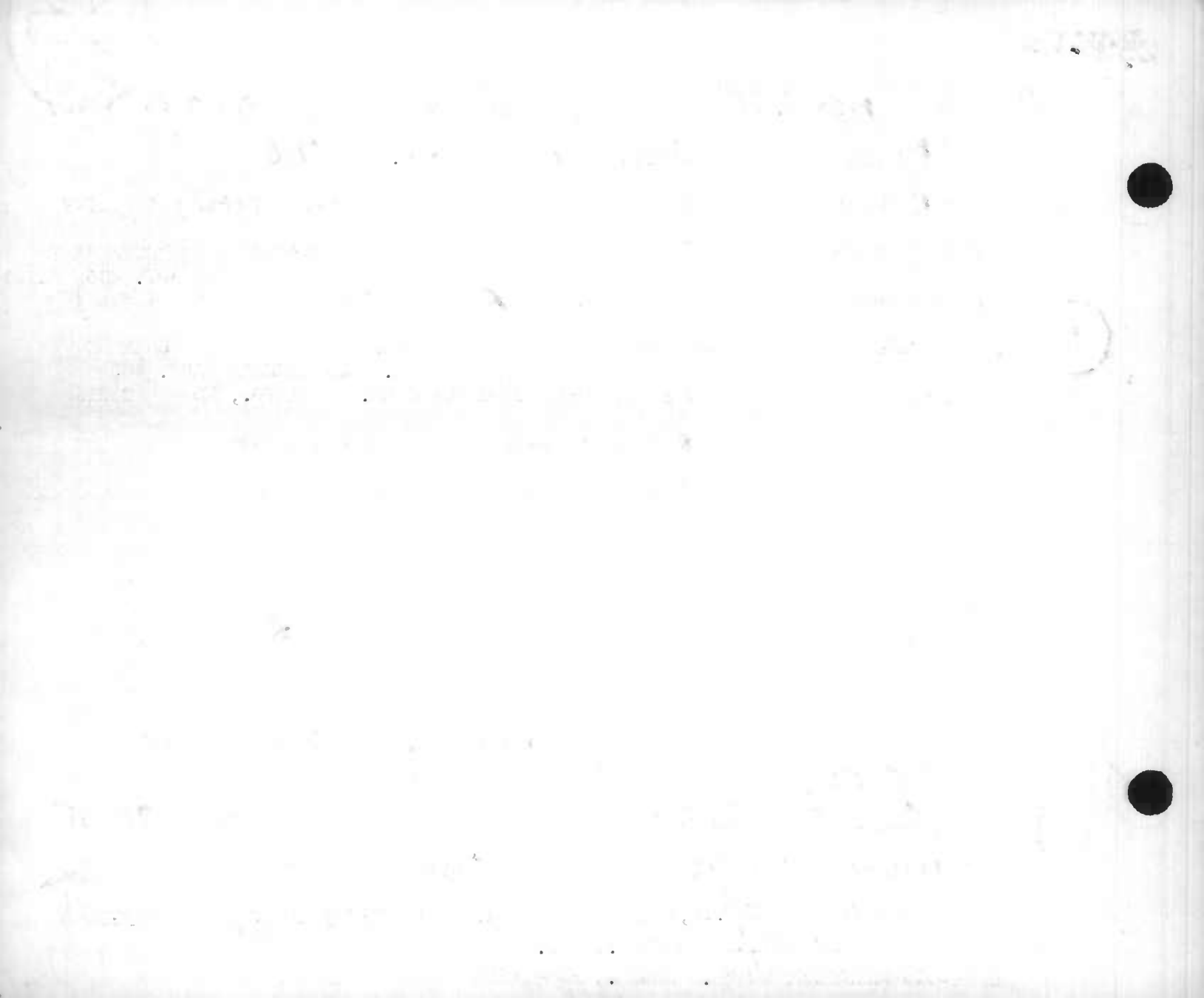
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MEYLAKH MIDDLE MEYLAKH LAST KARGMAN KARGMAN		2a. DATE OF DEATH MONTH DAY YEAR 9 9 85		2b. HOUR 5:45 P.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4 15 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY		13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3601 FORDS LA. APT. 406 #2121	
14. FATHER'S NAME FIRST ILYA MIDDLE KARGMAN LAST		15. MOTHER'S MAIDEN NAME FIRST RUCHEL MIDDLE UNKNOWN LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-92-7426		17. INFORMANT MRS. ROSA KARGMAN APT. 406 3601 FORDS LA. BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIFFUSE HISTIOCYTIC LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/27/85, 19 85, to 9/9/85, 19 85, that (I) (we) last saw the deceased alive on 9/9/85, 19 85, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rosa A. Goldstein MD		DEGREE		22c. DATE SIGNED 9/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MILAN WISTER		22e. ADDRESS SINAI HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE SEPT. 10, 1985	23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR SEP 13 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP



262115

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harold - Katz			2a. DATE OF DEATH MONTH 9 DAY 10 YEAR 85 2b. HOUR 7:35 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH June DAY 29 YEAR 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic-Service		12b. KIND OF BUSINESS OR INDUSTRY Amusement Co.
13a. STATE Md.		13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 3818 Woodlea Avenue 21206	
14. FATHER'S NAME Harry MIDDLE Katz LAST			15. MOTHER'S MAIDEN NAME Clara MIDDLE - LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW 2 216-18-6408		17. INFORMANT Mrs. Lorraine V. Katz ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) CA OF LUNG					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SIADH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/4 , 19 85 , to 9/10 , 19 85 , that (I) (we) last saw the deceased alive on 9/10 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David S. Dunn			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID S. DUNN MD			22e. ADDRESS 201 E. UNIVERSITY PKWY		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 13, 1985	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans Owings Mills		23d. LOCATION CITY OR TOWN Balto. COUNTY Md. STATE
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland			25a. DATE REC'D. BY REGISTRAR SEP 16 1985		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

10

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Notes - June 2, 1967

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273059

Film G608 item 1, 14, 15

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 25187

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
Joseph Squire Keeling Jr.								DATE OF ESTIMATE 9 24 1985				9 24 1985			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				2d. HOUR	
M	B	9 13 25		60 YRS.						9 24 1985				6:50 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		U.S.A.				Baltimore City MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		2115 Orleans Street													
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland						Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		2115 Orleans 21231					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Joseph S. Keeling Sr.				Levi Lillie Vie Dickerson Wallace											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
no				223-24-1284		Elizabeth Smith 2115 Orleans									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Thomas D. Smith, M.D.				111 Penn St. Balto MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL				9/27/85		Baltimore				Baltimore MD.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
W.C. March F/H Co. 1101 E. North Ave.						SEP 26 1985		Felia Davidson-Bond							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



RECEIVED
FEB 11 1964
U.S. AIR FORCE
HONOLULU

RECEIVED
FEB 11 1964
U.S. AIR FORCE
HONOLULU

RECEIVED
FEB 11 1964
U.S. AIR FORCE
HONOLULU



259054

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Kehoe			2a. DATE OF DEATH MONTH DAY YEAR September 7, 1985		2b. HOUR 6:18P.M.
3 SEX MALE	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Nov - 4 - 1902		6 AGE (IN YEARS LAST BIRTHDAY) YRS 82	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Kehoe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Cosgrove		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-01-0551		17 INFORMANT ADDRESS Mrs. Elizabeth Kehoe 2413 Bouldin St. 21224	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Cardiomyopathy with Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Thirty minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 6, 1985 to September 7, 1985 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on September 7, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (do not) view the body after death.					
22b. SIGNATURE Yuh-Chin Huang		DEGREE		22c. DATE SIGNED 9-8-1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yuh Chin Huang M.D.		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-10-85	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME Joseph N. Zannino Jr.		ADDRESS 2635 Conkling St.		25a. DATE REC'D. BY REGISTRAR SEP 10 1985	25b. REGISTRAR'S SIGNATURE Sylvia Davidson-Randall

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/B4
(VRA 15, 4)

BP 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





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253105

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										25189 REG. NO.		
1. FOR STATE REGISTRAR												
2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas M. Keil										2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 3 1985		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 20 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62		7c. DATE PRONOUNCED DEAD 9 3 1985		2d. HOUR 2:35P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore City			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 301 McMechen Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William S. Keil			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA DORSEY			13e. STREET ADDRESS 301 McMechen Street			21217			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES W.W-II			16b. SOCIAL SECURITY NO. 215127289			17. INFORMANT FAMILY RECORDS			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 9/4/85			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.						ADDRESS 111 Penn St.			Balto. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY AT SEA			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME EVANS CHAPLOF MCMORISS						ADDRESS 8800 HARFORD RD.			25a. DATE REC'D. BY REGISTRAR SEP 6 1985		25b. REGISTRAR'S SIGNATURE 	

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



268123

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 1 9 0

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

John H. Keith, Jr.

7a DATE OF DEATH MONTH DAY YEAR 9 18 85 7b HOUR 9:13 PM

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

MONTH DAY YEAR 08 13 30

6 AGE (IN YEARS LAST BIRTHDAY)

55 YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

California

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD.

10 CITY OR TOWN OF DEATH

Baltimore

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Univ. of Maryland Cancer Center

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Economist

12b KIND OF BUSINESS OR INDUSTRY

Private Enterprise

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b STATE 13c CITY OR TOWN

Maryland Montgomery/Chesapeake

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

3916 Montrose Drive Zip: 20815

14 FATHER'S NAME

John

MIDDLE

H

LAST

Keith Sr

15 MOTHER'S MAIDEN NAME

Cloise

MIDDLE

Snow

LAST

Snow

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

562-38-4914

17 INFORMANT

Mrs. Muriel Keith, Wife, Same as #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Septic Shock with Adult Respiratory Distress Syndrome 4 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Myelogenous Leukemia in blast crisis 5 months

DUE TO, OR AS A CONSEQUENCE OF

(c) Chronic Myelogenous Leukemia 4 yrs

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Hesperiella Cellulitis

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☒ NO ☐20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from September 1, 1985, to September 18, 1985, that (we) last saw the deceased alive on September 18, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

Russell R. DeLuca

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c DATE SIGNED

9/18/85

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Russell R. DeLuca

22e ADDRESS

22 South Greene St, Balt. Md.

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b DATE

September 20, 1985

23c NAME OF CEMETERY OR CREMATORY

Metropolitan Crematory

23d LOCATION

Alexandria

COUNTY

Virginia

STATE

24 FUNERAL DIRECTOR

NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland

25 DATE REC'D. BY REGISTRAR

SEP 23 1985

25 REGISTRAR'S SIGNATURE

John Davidson

H



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) maryann		LAST kelch		2a. DATE OF DEATH MONTH DAY HOUR 9-28-85		2b. HOUR 9	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 27 43		6. AGE (IN YEARS LAST BIRTHDAY) 42	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City	
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of MD. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Welkie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thersea Putch		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216 42 0132	
17. INFORMANT ADDRESS Robert Kelch 321 Stillwater Rd. 21221		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 8880 ACUTE SUBDURAL HEMATOMIA IMMEDIATE CAUSE (a) ACUTE SUBDURAL HEMATOMIA DUE TO, OR AS A CONSEQUENCE OF (b) FALL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) EPILEPTIC SEIZURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS 6 DAYS 6 DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO							
19a. DATE OF OPERATION SEPT 23/1985		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) FELL IN STORE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from SEPT 22 , 19 85 , to SEPT 28 , 19 85 , that (I) (we) lost saw the deceased alive on SEPT 28 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Charles J. [Signature]		DEGREE MD		22b. DATE SIGNED SEPT 28, 1985		22c. DATE SIGNED SEPT 28, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles J. [Signature]		22e. ADDRESS [Signature]		22f. ADDRESS [Signature]			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/1/85		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland	
24. FUNERAL DIRECTOR Brazdzinski Funeral Home Pa		25a. DATE REC'D. BY REGISTRAR OCT 1 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 5 1 9 2

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME WILLIAM HENRY Kelley (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR SEPT. 3, 1985				2b. HOUR 11:20 pm.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11/10 /1911		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY SEARS			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN LINTHICUM		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 609 CLEVELAND ROAD 21090			
14. FATHER'S NAME FIRST CLARENCE MIDDLE LAST KELLEY				15. MOTHER'S MAIDEN NAME FIRST MINNIE MIDDLE JEANETTE LAST RYLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 212-03-7591		17. INFORMANT ADDRESS MARY DOUGHERTY KELLEY 609 CLEVELAND ROAD 21090					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY CANCER & METASTATIC SPREAD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from SEPT 3 , 19 85 , to SEPT 3 , 19 85 , that (I) (we) last saw the deceased alive on SEPT 3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE CRAIG R. HALL				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CRAIG R. HALL				22e. ADDRESS St. Agnes Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 9-7-85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard Maryland			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 4107 WILKENS AVENUE		25a. DATE REC'D. BY REGISTRAR SEP 6 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85 25193

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT KENAN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 12, 1985		2b. HOUR 12:48 A	
3. SEX M		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 5 1 05		
6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO		
13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2604 E. Oliver St 21213		
14. FATHER'S NAME FIRST MIDDLE LAST JIMMY KENAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 116-10-5099		17. INFORMANT Hope Foster		17. ADDRESS 2604 E. Oliver St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) STROKE						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 9/12 85 , to 9/12/ 85 , that (I) (we) last saw the deceased alive on 9-12 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Edward M. Lukalski DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED 9/12/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD M. LUKALSKI		22e. ADDRESS 600 N. Wolfe At Balto. Md 21205		
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 9/11/85		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY		
23d. LOCATION CITY OR TOWN COUNTY STATE BAIA County MD		24. FUNERAL DIRECTOR NAME Locks Funeral Home		25a. DATE REC'D. BY REGISTRAR SEP 16 1985		
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Signature]		25d. REGISTRAR'S ADDRESS [Signature]		

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CHIEF OF BUREAU
NAVY DEPARTMENT
WASHINGTON, D.C.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 1 9 4

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
LEROY B KENDRICK					9 20 85					4 ⁰⁰ P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS.			
MALE	Col	10-25-14			70		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Mich.		U.S.A.					Baltimore city MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE CITY		PROVIDENT HOSPITAL BALTIMORE				Retired						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21207 2121 Windsor Garden Apt 429		
14. DECEASED'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
MARTIN				Kendrick	Nellie				Ross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>		225-10-4150		Mrs. Thelma Kendrick		Apt. C429 21207 2121 Windsor Garden						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>9-18</u> 19 <u>85</u> to <u>9-20</u> 19 <u>85</u> that (I) (we) lost saw the deceased alive on <u>9-20</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE SHER AFZAL HASHMI MD				DEGREE MD		22c. DATE SIGNED 9-20-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
SHER AFZAL HASHMI		2600 LIBERTY HEIGHTS AVE 21215										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
BURIAL		9-26-85		GARRISON Forestlawn		BALTO. Co. MD						
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Joseph L. Reuss		2222 W. North Ave				SEP 23 1985						

MEDICAL CERTIFICATION

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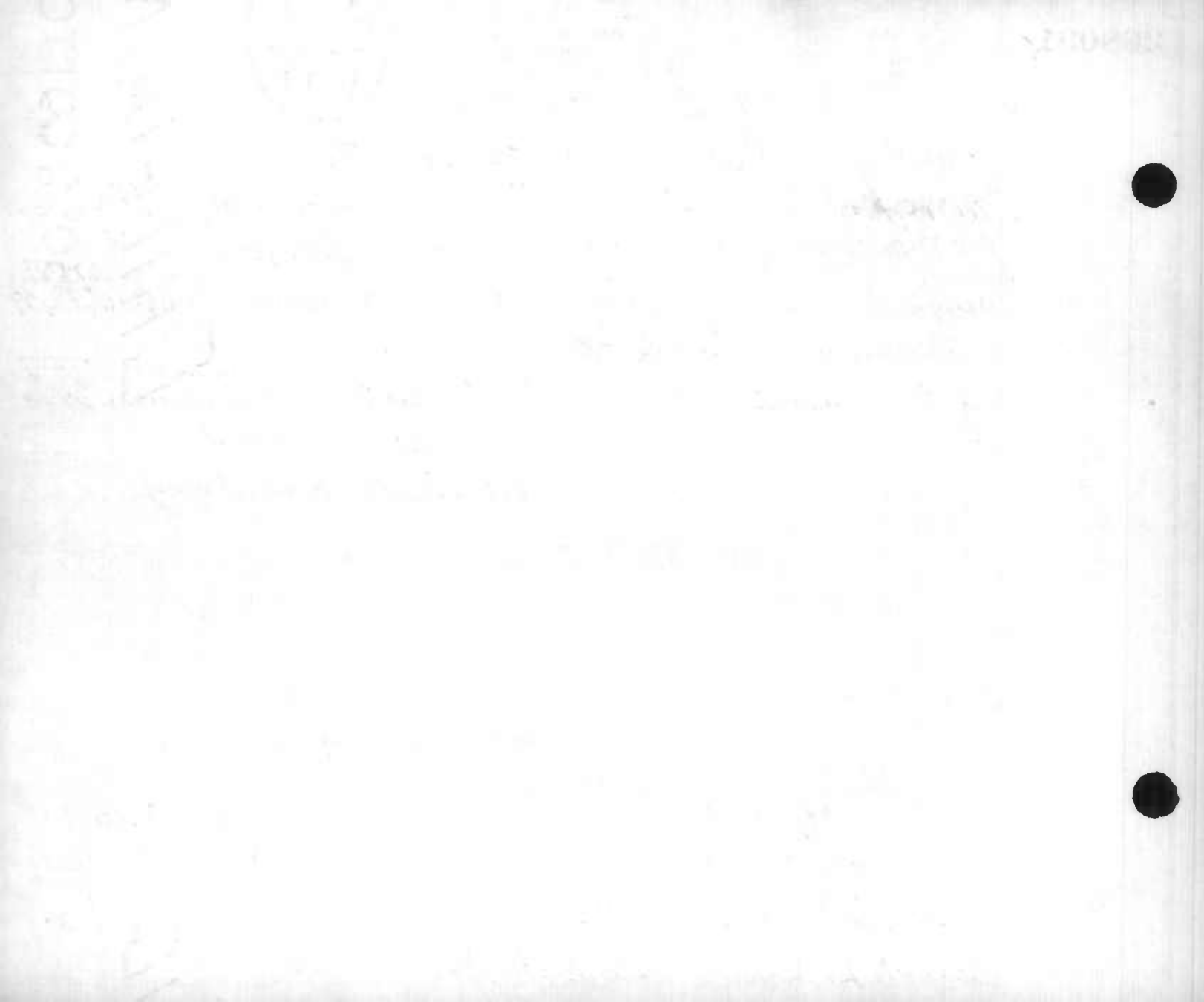
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified at once.

270017

FOR
STATE
REGISTRAR William F. Kenny Jr

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 1 9 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM F. KENNY Jr.			2a. DATE OF DEATH MONTH DAY YEAR 9 22 85		2b. HOUR 4:20 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 27 07		
6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE city MD.		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		11. CITIZEN OF WHAT COUNTRY? U.S.A		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Special Mechanic		
13a. CITY OR TOWN OF DEATH Baltimore		13b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore GEN.		12b. KIND OF BUSINESS OR INDUSTRY Fire Ext. Co.		
13a. STATE MD		13b. COUNTY Baltimore		13c. STREET ADDRESS / ZIP CODE 4110 Daune Ave 21225		
14. FATHER'S NAME FIRST MIDDLE LAST William F. KENNY Jr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lill McDonnell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 317053813		17. INFORMANT ADDRESS Patricia Baca 4321 Cortez Rd Balto Md 21225		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE COPD. PULM CA. DUE TO, OR AS A CONSEQUENCE OF (c) AS ABOVE. D.M. PNEUMONIA PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: D.M. PERFORATED PEPTIC ULCER						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Michael Kazak MD.		DEGREE MD.		22c. DATE SIGNED 9-22-85		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK		22c. ADDRESS 3001 So. HANDOVER ST.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/26/85		23c. NAME OF CEMETERY OR CREMATORY Westview Mem Park		
23d. LOCATION Catonsville		23e. BALTO		23f. STATE Md		
24. FUNERAL DIRECTOR NAME George J. Gonce 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR SEP 25 1985		
25b. REGISTRAR'S SIGNATURE June Davidson-Randall						

270017



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Handwritten notes and markings in the middle left, including a large '4' and some illegible scribbles.

Main body of the document containing multiple lines of extremely faint, illegible text, possibly a form or report.

252119

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25196
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST CAREY MIDDLE LAST KEY		2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 9-1 19 85		2b. HOUR M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 8 10 28	6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2821 E. Biddle Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND				
13b. COUNTY		13c. CITY OR TOWN BALTIMORE		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2821 E. BIDDLE ST. 21213		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 228-34-96-53		17. INFORMANT GAIL BISHOP ADDRESS 501 WINSTON ST.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Obesity</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>Dennis F. Smyta</i>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 9-1-85
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyta, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/6/85		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST
23d. LOCATION CITY OR TOWN OWINGS MILLS MD		23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR SEP 5 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

20% COTTON FIBER

LEWIS & CLARK



CHES

274112

FORM NUMBER 13c, PER. CALL

FOR
STATE
REGISTRAR

10-2-85 D.W.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 1 9 7

1. DECEASED NAME (TYPE OR PRINT) RAYMOND		FIRST MIDDLE LAST KIDD		2a. DATE OF DEATH MONTH DAY YEAR 9/24/85		2b. HOUR 6:00P.M.	
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 16 1912		6 AGE (IN YEARS LAST BIRTHDAY) 73 years	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ala		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH P.G.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. CITY OR TOWN PRINCE G.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 208 Weymouth St 20772	
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Kidd		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della R Boater		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 286-09-6136	
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16d. SOCIAL SECURITY NO. 286-09-6136		17 INFORMANT ADDRESS Annie Cook Vines 208 Weymouth St		17b. ADDRESS Upper Marlboro Md	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary anest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease			
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: High Blood pressure, chronic renal failure			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/24 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 9/16 1985 to 9/24 1985 , that (I) (we) lost the deceased alive on 9/24 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22a. SIGNATURE K. DESAI		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. DESAI		22e. ADDRESS North Charles General Hospital					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/1/85		23c. NAME OF CEMETERY OR CREMATORY Md Nat Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel md	
24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H Inc West 4300 Wabash Ave				25a. DATE REC'D BY REGISTRAR SEP 27 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the State Registrar, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

20% COTTON FIBER

MAINTAIN



SHIRTS

260066

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 1 9 8

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILSON KIDD			2a DATE OF DEATH MONTH DAY YEAR SEPT. 7, 1985		2b HOUR 1:55pm
3 SEX MALE	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR 8 15 16	6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BIRMINGHAM ALA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND			13b COUNTY	13c CITY OR TOWN BALTIMORE	
14 FATHER'S NAME FIRST MIDDLE LAST CHARLIE KIDD			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOVELY DATCHER		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-07-68-71		17 INFORMANT ADDRESS FLORENCE BISCOE 2601 GUILFORD AVE.	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) esophageal cancer DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wk. 6 mo.
PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Sept. 1 , 19 85 , to Sept 7 , 19 85 , that (I) (we) last saw the deceased alive on Sept 7 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE James Conkum		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 9-8-85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) James Conkum		22e ADDRESS JHH 601 N. WILKES ST BALTIMORE MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 9/11/85	23c NAME OF CEMETERY OR CREMATORY MT. CALVARY CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDAL CO. MD
24 FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE			25a DATE REC'D BY REGISTRAR SEP 11 1985		
25b REGISTRAR'S SIGNATURE [Signature]					

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DEFENSE INFORMATION REPORT

0 055 20 02

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR			REG. NO. 8525199						
1 DECEASED NAME (TYPE OR PRINT) FREDA E. KUEFER			2a DATE OF DEATH MONTH 9 DAY 11 YEAR 85				2b HOUR 6:50 AM		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH 12 DAY 9 YEAR 96		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.			
10 CITY OR TOWN OF DEATH BALTO CITY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON F. LOR				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY 	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b COUNTY 		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3308 O'DONNELL ST. 21224	
14 FATHER'S NAME FIRST JOO AUGUST MIDDLE LAST KIEFER			15 MOTHER'S MAIDEN NAME FIRST MARGARET MIDDLE LAST HENSHAW			16 ADDRESS WESTMINSTER MD. 30 LOCUST ST. APT 608			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 215-24-5742		17 INFORMANT ELLA L. JOY					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) ATRIAL FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a I certify that (I) this hospital attended the deceased from AUG 1 19 85 , to SEPT 11 19 85 , that (I) (we) last saw the deceased alive on SEPT 10 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Susan Denman MD DEGREE 				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 9/11/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Susan Denman				22e ADDRESS 5200 Eastern Ave Balt 21224					
23a BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b DATE 9-13-85		23c NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d LOCATION CITY OR TOWN BALTO COUNTY STATE MD.			
24 FUNERAL DIRECTOR HOFFMANN-SKARDA ADDRESS 3218 HUDSON ST				25a DATE REC'D. BY REGISTRAR SEP 13 1985		25b REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 5 2 0 0

1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Linton E Kilmon Sr.			2a. DATE OF DEATH MONTH DAY YEAR Sept 12 85		2b. HOUR 8:45 AM
3. SEX male	4. RACE White Auc	5. DATE OF BIRTH MONTH DAY YEAR 7 21 13	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD.		
10. CITY OR TOWN OF DEATH Balt City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wynman Park Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Dental Technician		
13a. STATE MD	13b. COUNTY Balt City	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2906 Cresmont AU 21211	
14. FATHER'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Kilmon		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lola Kirby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213 01 1975		17. INFORMANT ADDRESS Mr. Charles W. Kilmon 1219 Glenhaven Rd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Metastatic Squamous Cell CA of Lung

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

18a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 9-1-85, 19, to 9-12, 19 85, that (I) (we) last saw the deceased alive on 9-12, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE David B. Gattuso	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 9-12-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David B. Gattuso M.D.		22e. ADDRESS 3100 Wynman Park Drive	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 14, 1985	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 16 1985	25b. REGISTRAR'S SIGNATURE Felia Davidson-Rendell

BP

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

263136

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 2 0 1

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen M. Kimball			2a. DATE OF DEATH MONTH DAY YEAR 9 14 85		2b. HOUR 4 03 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 10 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 204 Oakwood Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Turner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Fritsch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-3329		17. INFORMANT Linda L. Clary		ADDRESS Same as Line 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 4 1/2		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7838 Eastern Ave., Balto., Md. 21224					
22a. I certify that (I) (this hospital) attended the deceased from 8-8-85 to 9-14-85 , that I saw the deceased on 8-29-85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) (did) (did not) view the body after death.									
22b. SIGNATURE J. Ardaz				DEGREE M.D. ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-16-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose Ardaz, M.D.P.A.				22e. ADDRESS 7838 Eastern Ave., Balto., Md. 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/18/85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh, Baltimore, MD			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR SEP 18 1985		25b. REGISTRAR'S SIGNATURE J. Ardaz			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Evelyn M. Kimos			2a. DATE OF DEATH MONTH DAY YEAR 9 12 85		2b. HOUR 12²⁴ AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 4, 1902		
6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
12b. KIND OF BUSINESS OR INDUSTRY Restaurant		13a. STREET ADDRESS / ZIP CODE 4811 Walther Ave. 21214				
13b. COUNTY Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Diamond Mandikos		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cassandra Hondrapapa				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 119-05-2602		17. INFORMANT ADDRESS Peter G. Kimos -12919 Gent Rd. Reisterstown, Md. 21136		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac & respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: b) intracranial bleed DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9-10 19 85 , to 9-11 19 85 , that (I) (we) lost saw the deceased alive on 9-11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED 9-11-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janine Good		22e. ADDRESS Union Memorial Hosp				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-14-85		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox		
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE [Signature]		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		ADDRESS 1050 York Rd.		25. SEP 16 1985		

SECRET

SECRET

GENERAL NO. 100-100

SECRET



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281017

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1 TO THE FUNERAL DIRECTOR. PAGE 2 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-1. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25203

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Doris King			XX MONTH DAY YEAR 9-30 19 85			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
FEMALE	WHITE	JAN. 5, 1906	79 YRS.	MONTHS	DAYS	9-30 19 85		5:40 P. M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND		USA				Baltimore City, MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		University Hospital			NURSE		MEDICINE	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		301 McMECHEN ST. #21217
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
SAMUEL MISLER			LENA BROOKMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO			213-28-8300		MRS. SARAH LEVY APT. 1 7020 PARK HTS. AVE. BALTO., MD 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY approx. 5:15 P.M. 9-30 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			street		1600 blk. Eutaw Street, Baltimore, Maryland			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Dennis F. Smyth, M.D.			Assistant MEDICAL EXAMINER			10-1-85		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Dennis F. Smyth, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL			OCT. 2, 1985		ANSHE EMOH		BALTIMORE MARYLAND STATE	
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					OCT 4 1985		Julia Davidson-Rodgers	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 2 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
RICHARD BRITON KING					9 15 85					9:10 A.M.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE	WHITE		8 10 05		80		MONTHS		DAYS		HOURS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		St. Agnes Hospital		Desk-Clerk		Motel					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN					
Maryland						Baltimore					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
David T. King				Susanna Fuhrman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		214-01-9205		Rosemary Cornelius		4050 Wilkens Ave.		21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE monocytic leukemia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>Chronic Renal failure @ CHF</u> <u>Disseminated intravascular coagulation</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u>9:10</u> MONTH <u>9</u> DAY <u>15</u> YEAR <u>1985</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>9/14/85</u> 19 <u>85</u> to <u>9/15/85</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>9/15/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M. Elnou</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/15/85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MOHAMED ELNOUR</u>		22e. ADDRESS <u>900 CATON AVE, 2P 21229</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		9/17/85		Loudon Park Cemetery		Baltimore				Maryland	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE OF BURIAL		25b. REGISTRAR'S SIGNATURE					
Hubbard Funeral Home, Inc.		4107 Wilkens Ave.		21229		<u>SEP 16 1985</u>					

BP

SEP 10 1963

20% LOW LIBER

WILLIAM BOWEN



SEP 10 1963

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lewis Anthony Kingsborough		2a. DATE OF DEATH MONTH DAY YEAR September 28 1985		2b. HOUR 9:00 P M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 28 1985		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 3 10	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEW BORN		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Rhudy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Karen Lynn Kingsborough			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED 9-28-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SACRANA M.P.		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/3/85		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 9 1985	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

287007

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7-21-0

September 23 1902

Memorandum

Number

Date

13

Sept. 24 1902

Subject

Place

Wash. D.C.

Wash. D.C.

Wash. D.C.

Wash. D.C.

Wash. D.C.

Wash. D.C.

Wash. D.C.

Wash. D.C.

Wash. D.C.

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MADE IN U.S.A.

Sept. 24 1902

280085

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) DOROTHY E KIRKENDALL			2a DATE OF DEATH MONTH 09 DAY 30 YEAR 1985			2b HOUR 6:30 P.M.					
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH OCT. DAY 16 YEAR 1912		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.					
10 CITY OR TOWN OF DEATH BALTO. CITY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GEN. HOSPT.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD. 13b COUNTY BALTO. CO. 13c CITY OR TOWN BALTO.				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3025 CHESNUT AVE 21222					
14 FATHER'S NAME FIRST MIDDLE LAST 				15 MOTHER'S MAIDEN NAME FIRST JULIA MIDDLE ELIZABETH LAST JOHNSON							
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 214-74-1539		17 INFORMANT ADDRESS FAMILY RECORDS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PELVIC LIPOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a DATE OF OPERATION 08/22/85			19b CONDITION FOR WHICH OPERATION WAS PERFORMED PELVIC LIPOMATOSIS			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 			21f LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a I certify that (I) (this hospital) attended the deceased from 08/06/85 to 09/30/85 , that (I) (we) last saw the deceased alive on 09/30/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Arthur R. Evans						DEGREE 		22c DATE SIGNED 09/30/85			
22d PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR R. EVANS MD						22e ADDRESS NORTH CHARLES HOSPITAL T3 BALTIMORE, MD 21218					
23a BURIAL, CREMATION, REMOVAL BURIAL			23b DATE 10-4-1985		23c NAME OF CEMETERY OR CREMATORY MORELAND MEM. PARK		23d LOCATION CITY OR TOWN PARKVILLE COUNTY BALTO. CO. STATE MD.				
24 FUNERAL DIRECTOR EVANS CHAPEL OF MEMORIES						25a DIED BY REGISTRATION YES		25b REGISTRAR'S SIGNATURE W. J. Anderson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, it should be marked on item 18.

BP

280082

3



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259122

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FRANK		FIRST MIDDLE LAST KIRKLAND		2a. DATE OF DEATH MONTH DAY YEAR 9 10 85		2b. HOUR 10:47P _M	
3 SEX M.		4 RACE B.		5. DATE OF BIRTH MONTH DAY YEAR 4 14 47		6 AGE (IN YEARS LAST BIRTHDAY) 38 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10 CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST J. D. Kirkland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Carston		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. 167-69		17. INFORMANT Mrs. Frances Kirkland		ADDRESS 416 N. Hilton			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOL ABUSE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that X (this hospital) attended the deceased from 8/29/85, 19 to 9/10, 1985, that (we) last saw the deceased alive on 9/10/85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (not) view the body after death.							
22b. SIGNATURE T. Nguyen MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/11/85	
22d. PHYSICIAN'S NAME THUY VI NGUYEN		22e. ADDRESS VAMC, Baltimore, Maryland 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-13-85		23c. NAME OF CEMETERY OR CREMATORY Crowsville Vet.		23d. LOCATION Crowsville, Md. STATE	
24. FUNERAL DIRECTOR NAME Jas. A. MORTON & SONS				ADDRESS 1701 Laurens		25a. DATE REC'D. BY REGISTRAR SEP 13 1985	
				25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed and signed by the attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. The first part of the report
describes the general situation
of the country and the
state of the economy.
It also mentions the
main problems of the
country and the
state of the economy.
The second part of the
report describes the
main problems of the
country and the
state of the economy.
The third part of the
report describes the
main problems of the
country and the
state of the economy.

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describes the general situation
of the country and the
state of the economy.
It also mentions the
main problems of the
country and the
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The second part of the
report describes the
main problems of the
country and the
state of the economy.
The third part of the
report describes the
main problems of the
country and the
state of the economy.

275078

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Howard	MIDDLE Rand	LAST Kirkpatrick	2a. DATE OF DEATH MONTH DAY YEAR 09 -29-85		2b. HOUR 0605a_M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 19 14		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Government		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government		
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 403 Hance Ave. 21090
14. FATHER'S NAME FIRST MIDDLE LAST Thomas B. Kirkpatrick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha E. Hill		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				
16b. SOCIAL SECURITY NO. 217-09-7755		17. INFORMANT ADDRESS Ada A. Kirkpatrick 403 Hance Ave. 21090		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute tracheobronchitis + bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral ischemia (cardiac arrest + stroke) DUE TO, OR AS A CONSEQUENCE OF (c) Coronary thrombosis + old + probable recent MI CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/25 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE St Agnes Hospital Baltimore Maryland				
22a. I certify that (I) (this hospital) attended the deceased from 9/25 19 85 , to 9/29 19 85 , that (I) (we) last saw the deceased alive on 9/29 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.								
22b. SIGNATURE William J. Hicken MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WJ HICKEN MD		22e. ADDRESS St Agnes Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/2/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Maus.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR SEP 30 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be certified by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

BP

075018

CHARLES W. WILSON



RECEIVED OCT 10 1964

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263083

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
TIMBERLATE				KIRVEN	9	7	85		11:18aM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE	BLACK	July 25 1911		74	MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
South Carolina	U.S.A.			BALTIMORE CITY, MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE	VAMC 3900 LOCH RAVEN BLVD		Chef		Restaurant				
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE					
Maryland		Cecil		Elkton		269 G. Kirk Road 21921			
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Dozier		Kirven		Rosa Slater					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
YES		180123983		Delphine Kirven					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ASYSTOLE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 MINS

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

SEVERE METABOLIC ACIDOSIS

24 HRS

DUE TO, OR AS A CONSEQUENCE OF

BILATERAL ILLAC ARTERY OCCLUSION 5-7 DAY

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

PSEUDOTUMORAL COLITIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
9/11/85	ISCHEMIC LOWER EXT	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from AUGUST 30 19 85 to SEPTEMBER 7 19 85 that (we) lost saw the deceased above, (we) did not view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
THOMAS H WEAB	MD	9/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
THOMAS H WEAB	3900 LOCH RAVEN BLVD BALTO, MD 21218		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	9-12-85	Rolling Green	West Chester Pennsylvania
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Chris W. Davidson	SEP 17 1985		Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

820535



REBIT MOTION PICTURE

WILLIAM W. WALKER

Charles Chaplin

277041

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

B 5 2 5 2 1 0

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rosalie Magdalene Klecz</i>			2a DATE OF DEATH MONTH DAY YEAR <i>September 29, 1985</i>		2b HOUR <i>2:00^A_M</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8 30 14</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10 CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>331 South Macon Street 21224</i>		12a USUAL OCCUPATION (TYPE OF WORK OR MOS) OF WORKING LIFE <i>Retired</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Hutzler Bros.</i>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i>			13b COUNTY <i>—</i>	13c CITY OR TOWN <i>Baltimore</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <i>Miller</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>212-10-4092</i>		17 INFORMANT ADDRESS <i>Manassas Va. Lawrence Klecz 12318 Running Deer Rd. 22111</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic a. feb. with controlled ventric response, M. tral valve</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>CHF, chronic a. feb. with controlled ventric response, M. tral valve</i>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>6</i> 19 <i>85</i> , to <i>9/25</i> 19 <i>85</i> that <i>(I)</i> (we) last saw the deceased alive on <i>9/25</i> 19 <i>85</i> , and that in my <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above <i>(I)</i> (we) did not view the body after death.					
22b SIGNATURE <i>Joseph D'Antonio, Jr., M.D.</i>		DEGREE <i>M.D.</i>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph D'Antonio, Jr., M.D.</i>		22e ADDRESS <i>7401 Osler Drive - St. 210 21204</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b DATE <i>10-2-85</i>	23c NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Arlington, Arlington Co., Va.</i>	
24 FUNERAL DIRECTOR NAME <i>Charles S. Zeiler & Son Inc.</i>		ADDRESS <i>6224 Eastern Ave.</i>		25a DATE REC'D. BY REGISTRAR <i>OCT 1 1985</i>	25b REGISTRAR'S SIGNATURE <i>John Davidson</i>

MEDICAL CERTIFICATION

9
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

277056

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SYLVESTER JAMES KLINE SR.			2a. DATE OF DEATH MONTH DAY YEAR 9-27-85		2b. HOUR 10:30AM
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 15 12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH City (Baltimore) MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3717 St. Margaret St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter Helper	12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST DENNIS EDWARD KLINE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA STRASSLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT Alta Jean Kline 3717 St. Margaret St. - Balto., Md. 21225			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UPPER GI- HEMORRHAGE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGEAL VARICES					
DUE TO, OR AS A CONSEQUENCE OF (c) PORTAL CIRRHOSIS OF THE LIVER.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARCINOMA OF THE BLADDER, OBSTRUCTIVE UROPATHY.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-11-78, 19____, to 9-27-85, 19____, that (I) (we) last saw the deceased alive on 8-15-85, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE K. Dharmasena M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-27-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. DHARMASENA, M.D.		22e. ADDRESS #8-16th Avenue - Baltimore, Maryland 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/30/85	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md	
24. FUNERAL DIRECTOR George J. Gonca		4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR OCT 1 1985	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies of pages 1 and 2, and page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

22708

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CHIEF

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

276082
104

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 2 1 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Shaddeus</i> <i>Klus</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9-22-85</i>			2b. HOUR <i>11:30 PM</i>				
3. SEX <i>Male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 31, 1922</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>YRS.</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Air Traffic Sup.</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Md.</i>			13b. CITY OR TOWN <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>2103 Kalb Manor Rd. 21207</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter</i> <i>Klus</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna</i> <i>Jedak</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>185-16-7267</i>		17. INFORMANT ADDRESS <i>Margaret Klus 2103 Kalb Manor Rd.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac leg. failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Melanotic Adeno CA</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>										
19a. DATE OF OPERATION <i>-</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>9-5-</i> , 19 <i>85</i> , to <i>9-22-</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Seag</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>9/22/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>TRADEEP GARG</i>				22e. ADDRESS <i>St. Agnes Hosp. Balto Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9-26-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Crest Lawn Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sykesville Md.</i>				
24. FUNERAL DIRECTOR NAME ADDRESS <i>Weber Funeral Home 5311 Edmondson Ave.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 1 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John A. Henderson</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MAURICE E. KNIGHT			2a. DATE OF DEATH MONTH DAY YEAR 9 30 85			2b. HOUR 11:00AM				
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 5 21 16		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3201 Georgetown Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.C. Porer		12b KIND OF BUSINESS OR INDUSTRY Kiser Aluminium		
13a STATE Maryland			13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST William Knight			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Meridath			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				
16b SOCIAL SECURITY NO. 216-01-7167			17 INFORMANT Mildred J. Knight			ADDRESS 3201 Georgetown Rd. 21230				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Bile Ducts DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/10 1985			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21i LOCATION STREET CITY OR TOWN COUNTY STATE 5550 Baltimore National Pike Baltimore Maryland				
22. I certify that (I) (this hospital) attended the deceased from 8/10 19 85 , to 9/30 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and I) (and I) view the body after death.										
22a SIGNATURE J. McPhillips			22b DEGREE PHYSICIAN			22c ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 9/30/85	
23a. BIRTH, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/3/85			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.			24b. ADDRESS 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR OCT 2 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STENTS



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269051

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FREDERICK — KOCH			2a. DATE OF DEATH MONTH 9 DAY 18 YEAR 85			2b. HOUR 11⁰⁰ AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 2 YEAR 28		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Apt. Complex	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4402 Annapolis Rd. 21227	
14. FATHER'S NAME FIRST John MIDDLE Henry LAST Koch				15. MOTHER'S MAIDEN NAME FIRST Dorothy MIDDLE Ernestine LAST Neugebauer				16. ADDRESS Baltimore Md. 21227	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Katherine Koch		17. ADDRESS 4402 Annapolis Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT, ACUTE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS CORONARY ARTERY, DUE TO, OR AS A CONSEQUENCE OF (c) LEFT, SEVERE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DIABETES MELLITUS									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Michael E. Pappas</i> DEGREE MD						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 9-21-85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME McCully Funeral Home ADDRESS 47 E. Patapsco Ave. Balto. Md. 21225						25a. DATE REC'D. BY REGISTRAR SEP 24 1985		25b. REGISTRAR'S SIGNATURE <i>F. Davidson-Randall</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director after 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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CHIEFMAN

20 COLM



2741140

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 2 1 5

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR A M
WILLIAM		FRED	KONGRO		09-15-85	5:25
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	Oct. 22, 1901		83 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	U.S.A.			Baltimore City MD.		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore	Belair Convalesarium		Musician		Entertainment	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE		13b CITY OR TOWN	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d STREET ADDRESS / ZIP CODE		
Maryland		Harford	Churchville	212 Hopewell Rd./21028		
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Augustus Kongro		Sophie UNK				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS		
NO		N/A		21028 Chas.A.Kongro, 212 Hopewell Rd., Churchville, MD		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>DIETETIC PERIPHERAL</u> DUE TO, OR AS A CONSEQUENCE OF <u>VASCULAR DIS.</u> (b) <u>CANCER BOTH FEET</u> (c) <u>CANCER BOTH FEET</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC CONGESTIVE HEART FAILURE</u>		

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9-02-85</u> , 19 <u>85</u> , to <u>09-15-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>09-01-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.			
22b SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN	
22c PHYSICIAN'S NAME (TYPE OR PRINT) Luis E. Rivera, MD.		22d ADDRESS 54 Scott Adam Road Cockysville, Maryland 21030	

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Removal/Cremation	Sep. 16, 1985	R.A. Ferris and Co.	West Chester, Chester, Penna.
24 FUNERAL DIRECTOR NAME ADDRESS		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE	
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399		23 1985 [Signature]	

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20% COTTON FIBER



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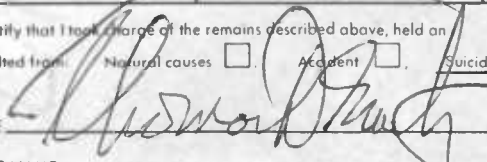
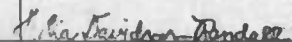
20% COTTON
MADE IN
CHINA

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273067

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORNATIM RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										25217 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Leocadia Kozlowski						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 9 23 1985		2b. HOUR M			
3 SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH OCT 13, DAY 1924 YEAR 60		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS 60 DAYS 0 HOURS 0 MIN 0		7c. DATE PRONOUNCED DEAD 9 23 1985		7d. HOUR 3:12P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 517 S. Lakewood Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 517 S. LAKEWOOD AVE. 21224		
14. FATHER'S NAME FIRST PAUL MIDDLE SOWA LAST BERTHA						15. MOTHER'S MAIDEN NAME FIRST BERTHA MIDDLE KENDRA LAST KENDRA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216/20/0325		17. INFORMANT ADDRESS EMIL KOZLOWSKI 517 S. LAKEWOOD AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 3+ MONTH 9 DAY 23 YEAR 1985 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 517 S. Lakewood Drive, CITY OR TOWN Baltimore City, COUNTY BALTIMORE STATE MD.					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Acting Chief				DATE SIGNED _____			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto.MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 9/27/85		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		23d. LOCATION CITY OR TOWN BALTIMORE CITY, COUNTY BALTIMORE STATE MD.			
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI ADDRESS 2525 FLEET ST.						25a. DATE REC'D. BY REGISTRAR SEP 26 1985		25b. REGISTRAR'S SIGNATURE 			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 2 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HERMAN EDWARD KLEIN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 8, 1985		2b. HOUR 7:23P.M.				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 23, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR-I.R.S.		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6004 IVYDENE TERRACE 21209	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN H. KLEIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH KRAVETZ					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-9557		17. INFORMANT ADDRESS MRS. MARGIT KLEIN 6004 IVYDENE TERRACE 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 6 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>1940</u> to <u>August 85</u> , that (I) <u>did</u> <u>not</u> lose sight of the deceased alive on <u>August 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> <u>not</u> view the body after death.									
22b. SIGNATURE <u>Julius C. Gluck, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>9/9/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JULIUS GLUCK						22e. ADDRESS 6014 CROSS COUNTRY BLVD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/10/85		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215						25a. DATE REC'D. BY REGISTRAR SEP 13 1985			
25b. REGISTRAR'S SIGNATURE									

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

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REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MORRIS KLEIN				2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 2, 1985		2b. HOUR P. M. 11:30 P.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 5, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5670 THE ALAMEDA, APT. C				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COLLECTOR	
12b. KIND OF BUSINESS OR INDUSTRY CREDIT BUREAU OF BALTO.		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND BALTIMORE					
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5670 THE ALAMEDA, APT. C #21239					
14. FATHER'S NAME FIRST MIDDLE LAST JACK KLEIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHAEL UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-ARMY 217-14-0514		17. INFORMANT MRS. LEONA KLEIN APT. C 5670 THE ALAMEDA BALTO., MD 21239			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL CELL CA LONG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen H. Glassner</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN GLASSNER, M.D.				22e. ADDRESS 600 REISTERSTOWN RD. BALTO., MD 21208			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 5, 1985		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR SEP 9 1985		25b. REGISTRAR'S SIGNATURE <i>P. Davidson-Randall</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruby Mae Knorr		2a. DATE OF DEATH MONTH DAY YEAR September 5, 1985		2b. HOUR 11:35A	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 22 22		6. AGE (IN YEARS LAST BIRTHDAY) 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper	
13a. STATE Maryland		13b. COUNTY _____		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST James Silcox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Damer Tillis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. 2 264-16-2535		17. INFORMANT ADDRESS George Knorr 3103 Fait Avenue 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraoperative bleeding possible DUE TO, OR AS A CONSEQUENCE OF (b) dissemination intravascular coagulation DUE TO, OR AS A CONSEQUENCE OF (c) portal hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from August 10, 19 85 to September 5, 85 , that (I) (we) last saw the deceased alive on September 5, 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 9/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Y. K. SHETTY		22e. ADDRESS 100 N. Broadway CHURCH HOSPITAL, BALT, MD 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-9-85		23c. NAME OF CEMETERY OR CREMATORY Kingsley Lake	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		ADDRESS 901 S. Conkling St.		25a. DATE REC'D. BY REGISTRAR SEP 6 1985	
				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonation. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

BP

259145

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 2 2 1

1. DECEASED NAME (TYPE OR PRINT) SARA (Sue) F. Kolker			2a. DATE OF DEATH MONTH DAY YEAR 09 06 85		2b. HOUR 10:00 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 14 23	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE USA - MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Balto.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JACOB millstein			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Spector		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] UNKNOWN			16b. DATE OF SERVICE 17. INFORMATION SIDNEY KOLKER 5317 WABASH AVE. #21215		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Colon Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Pneumonia, Anemia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~1 yr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION 9/20/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from Aug 4, 19 85, to Sept 6, 19 85, that (1) we lost saw the deceased alive on Sept 6, 19 85, and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) well did (1) did not view the body after death.					
22b. SIGNATURE Marcia D. Wolf MD 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCIA D. WOLF				22c. DATE SIGNED 9/6/85	
22e. ADDRESS Sinai Hosp of Balto				22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN	
23d. LOCATION CITY OR TOWN BALTIMORE		23e. COUNTY BALTIMORE		23f. STATE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25. DATE REC'D. BY REGISTRAR SEP 13 1985	
26. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Florence V. Kosmicky			2a DATE OF DEATH MONTH DAY YEAR 9/1/85			2b HOUR 5:21 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 4 3 21		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7 IF UNDER 1 YEAR MONTHS DAYS 4 29	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hosp. Inc.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector Continental Can		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD. 13b COUNTY — 13c CITY OR TOWN Baltimore				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4425 Shamrock Ave 21206			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph F. Kosmicky				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Veronica Abrenski					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 218 076429		17 INFORMANT ADDRESS 7920 Bank St. Raymond Kosmicky (brother) 21224					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) resp. failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) perforated bowel								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a pleural effusion, HTN, DM, gangrene (L) leg, arrhythmias									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 6/19/85 , 19 85 , to 9/1/85 , 19 85 , that (I) (we) last saw the deceased alive on 9/1 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.)									
22b SIGNATURE J. Schimandle, MD				DEGREE MD				22c DATE SIGNED 9/1/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. Schimandle, MD				22e ADDRESS Mercy Hosp. Inc.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/4/85		23c NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24 FUNERAL DIRECTOR NAME Schimunek Funeral Home Inc. ADDRESS 3331 Brehms Lane, Balto. Md. 21213				25a DATE REC'D. BY REGISTRAR SEP 5 1985		25b REGISTRAR'S SIGNATURE —			

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case of a death.

031933

RECEIVED

NOV 10 1953



NOV 10 1953

NOV 10 1953

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE BURIAL, CREMATION, OR REMOVAL INFORMATION IN ITEM 23. THIS PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REMAINS. THIS PAGE 5 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (1))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25223

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Doris L. Kreisel			2a. DATE KNOWN OF DEATH ESTIMATED 9 16 1985			2b. HOUR 11PM				
3. SEX Female	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 17 1920	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 9 16 1985	2d. HOUR				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2916 Sylvan Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2916 SYLVAN AVE		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES WESLEY KELLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRTLE FRANCES WHITE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 14 8985		17. INFORMANT FAMILY RECORDS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Dennis F. Smyth, M.D.			TITLE (SPECIFY) Assistant			DATE SIGNED 9/17/85				
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St. Balto. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-20-1985		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MARYLAND			
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES			ADDRESS 8800 HARFORD ROAD		25a. DATE REC'D. BY REGISTRAR SEP 18 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

100125

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2000 COLLO

WINTER



MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM T. KRESKE JR.				09 16 85			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23 1976		6. AGE (IN YEARS LAST BIRTHDAY) 8	
7a. BIRTHPLACE (STATE OR COUNTY) Del. =Wilmington,		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware 13b. COUNTY 13c. CITY OR TOWN Wilmington				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 12 May Ave. New Castle, Md. 19720			
14. FATHER'S NAME FIRST MIDDLE LAST William T. Kreske, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joann Begatto			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. none		17. INFORMANT 2309 Lancaster Ave. Wil., Del. Chas. P. Arcaro Fun. Home 19805	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Death						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0	
DUE TO, OR AS A CONSEQUENCE OF (b) Increased intracranial pressure						12 h	
DUE TO, OR AS A CONSEQUENCE OF (c) Presumed cerebritis						24 h	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/12, 19 85, to 9/16, 19 85, that (I) (we) last saw the deceased alive on 9/16, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Reid Thompson M.D.				DEGREE M.D.		22c. DATE SIGNED 9/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Reid Thompson M.D.				22e. ADDRESS Johns Hopkins Hospital St. Balt.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/20/85		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Delaware	
24. FUNERAL DIRECTOR NAME Joseph N. Zannino, 263 S. Conkling St.				25. DATE REC'D. BY REGISTRAR 17 SEP 1985 REGISTRAR'S SIGNATURE Julia Davidson			

SECRET



Handwritten markings, possibly a signature or initials, located in the lower left area.

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

2601000

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELsie KUDRNA			2. DATE OF DEATH MONTH DAY YEAR 9 9 85 12:45 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 11 02	
6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS.		7. CITIZEN OF WHAT COUNTRY? USA		8. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 809 N. PORT ST	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -----		13. STREET ADDRESS 809 N. PORT ST. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST ANTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANTOINETTE MAROUSEK		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
17. INFORMANT ADDRESS GEORGE F. KUDRNA 809 N. PORT ST.		18. SOCIAL SECURITY NO. 212462584		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Atrial fibrillation with embolism to (R) femoral artery</u>					
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> 19 <u>76</u> , to <u>9/9</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>4/2</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Nelson C. Sun</u>		22c. DATE SIGNED 9/10/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) NELSON C. SUN, MD	
22e. ADDRESS 301 ST. PAUL PLACE BALT. MD		22f. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. CITY OR TOWN BALTO.	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9/12/85		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	
23d. LOCATION CITY OR TOWN BALTO.		23e. COUNTY ---		23f. STATE MD.	
24. FUNERAL DIRECTOR NAME <u>Cheney Ave</u>		24b. ADDRESS 1211 Cheney Ave		24c. DATE REC'D. BY REGISTRAR SEP 11 1985	
24d. REGISTRAR'S SIGNATURE <u>Nelson C. Sun</u>		24e. REGISTRAR'S NAME Nelson C. Sun		24f. REGISTRAR'S ADDRESS 1211 Cheney Ave	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

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262038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) CAROLINE BROTHNER R. Kuehn				2a DATE OF DEATH MONTH DAY YEAR 9/11/85		2b HOUR 9:09 PM	
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 17 10 12		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator-St. Agnes Hospital		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Adolph Fielitz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fredia Keuler		16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS 1413 Lincoln Woods Drive - Balto., Md. #21228	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Profound Congestive Heart failure		DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery disease		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 9/11 , 19 85 , to 9/11 , 19 85 , that (I) (we) last saw the deceased alive on 9/11 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Papulis MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 9/11/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) PAPULIS		22e ADDRESS 22 S Greene St Balto MD 21201					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9-16-85		23c NAME OF CEMETERY OR CREMATORY Western Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24 FUNERAL DIRECTOR NAME G. Traiman SUTWAB		24b ADDRESS 111 BALTO. NAT'L. PIKE # 21229		25a DATE REC'D. BY REGISTRAR SEP 16 1985		25b REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

1

275116

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 2 2 8
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JOSEPH G. KUHN			2a. DATE OF DEATH MONTH DAY YEAR 9 24 85		2b. HOUR 2:24a M					
3 SEX Male		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 2/18/23		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD				
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VETERANS ADMINISTRATION MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS, OR SERVICE DURING LIFE) Quality Control		12b. KIND OF BUSINESS OR INDUSTRY Asarco		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3418 Juneway 21213	
14 FATHER'S NAME FIRST MIDDLE LAST George Kuhn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Gleich							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 216090074			17. INFORMANT ADDRESS Felicia Kuhn (wife) same address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure / encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GI bleed</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis</u> Approximate interval between onset and death days days years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Metastatic adenocarcinoma</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>SEPTEMBER 9</u> 19 <u>85</u> to <u>SEPTEMBER 24</u> 19 <u>85</u> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>SEPTEMBER 24</u> 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>S. Marshall MD</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/24/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. Marshall MD</u>			22e. ADDRESS 3900 LOCH RAVEN BLVD BALTO, MD 21218							
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Cremation			23b. DATE 9/26/85		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION Balto., Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213						25a. DATE REC'D. BY REGISTRAR SEP 30 1985		25b. REGISTRAR'S SIGNATURE <u>Gina Davidson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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21/11/72

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified of date.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Shirley E. KUMMER		2a. DATE OF DEATH MONTH 9 DAY 7 YEAR 85 TIME 0100	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH 7 DAY 3 YEAR 26	
7a. BIRTHPLACE (COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	6 AGE (IN YEARS LAST BIRTHDAY) 59	
10 CITY OR TOWN OF DEATH BALTIMORE		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of MD. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORK LIFE) HOUSE WIFE	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME			

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 125 CHESTER ST 21231
14. FATHER'S NAME WILLIAM FRANK PARKS		15. MOTHER'S MAIDEN NAME HELEN V. LEIGHT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 22 0337	17. INFORMANT ADDRESS 21224 Kummer, Sharon 506 S. ROBE ST	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Resp. Failure DUE TO, OR AS A CONSEQUENCE OF (b) Shock DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **NO**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 6 , 19 85 , to Sept 6 , 19 85 , that (I) (we) lost saw the deceased expire on Sept 6 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not visit the body after death.			
22b. SIGNATURE Daniel K. Bregman		DEGREE MD 22c. ADDRESS 22 S. Greene St. Balt MD	22d. DATE SIGNED 9/7/85
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel K. Bregman MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 9-10-85	23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD
24. FUNERAL DIRECTOR NAME OLIPPEH FURBER ADDRESS HOME BELAIR RD		25a. DATE REC'D. BY REGISTRAR SEP 11 1985	25b. REGISTRAR'S SIGNATURE [Signature]

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



253124

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 2 3 0

| | | | | | | | | | | | | | |
|--|--|---------------------|---|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LURINA | | | 2a. DATE OF DEATH
MONTH 9 DAY 4 YEAR 85 | | | 2b. HOUR
8¹⁰ P.M. | | | | | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH 10 DAY 14 YEAR 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS
HOURS 0 MIN. 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | | MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deacon Hosp. Medical Center | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
2226 Linden Avenue 21217 | |
| 14. FATHER'S NAME
FIRST Lonnie MIDDLE Daniels LAST Daniels | | | 15. MOTHER'S MAIDEN NAME
FIRST Lillie MIDDLE Mae LAST Moses | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | | 16b. SOCIAL SECURITY NO.
249-38-1491 | | | 17. INFORMANT
Ida Mae McFadden 2226 Linden Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: Ischemic cardiomyopathy
(b) Ischemic cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: End stage liver failure, Uremia | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 30 Aug 19 85 to 4 Sept 19 85 , that (I) (we) lost 4 Sept 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
One Ant. Carney MD | | | | | | DEGREE | | | 22c. DATE SIGNED
5 Sept 85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.C. CAWNE | | | | | | 22e. ADDRESS
611 B Charles Balt MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
9/9/85 | | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Mem. Pk. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 6 1985 | | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | | | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 5 2 5 2 3 1

| | | | | | | | | | | |
|---|--|---|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John GEORGE Lahita | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 29 85 | | | 2b. HOUR
405 M | | | | |
| 3 SEX
M | | 4 RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 24 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | 6. AGE (IN YEARS LAST BIRTHDAY)
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Med. Ctr. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chimney installer | | 12b. KIND OF BUSINESS OR INDUSTRY
Chimm. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MD | | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Westminster | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1075 Stone Road 21157 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Lahita | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susana H. Kostovcik | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
Veronica Lahita | | 17. ADDRESS
13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Healy | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/29/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Healy | | | | | | 22e. ADDRESS
F2 K Mc | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
10/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Finksburg Carroll MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert K. Pritts, Sr., | | | | | | ADDRESS
Westminster, Md. | | 25. DATE REC'D. BY REGISTRAR
OCT 04 1985 | | |
| | | | | | | 26. REGISTRAR'S SIGNATURE
J. A. Davidson | | | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to page 4, pages 1 and 2 should be filled in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

550/25

269107

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 2 3 2
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY EMMA LAIR | | | 2a. DATE OF DEATH
MONTH 9 DAY 22 YEAR 85 | | 2b. HOUR
5:45 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 9 DAY 2 YEAR 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
117 N. Highland Ave 21224 |
| 14. FATHER'S NAME
FIRST Thomas MIDDLE Davison LAST Greason | | 15. MOTHER'S MAIDEN NAME
FIRST Louisa MIDDLE Englehart LAST Englehart | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-50-7482 | | 17. INFORMANT
ADDRESS
Margaret L. Button -7 Bonrock Ct. 21204 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sigmoid carcinoma, perforated | | | | | |
| 19a. DATE OF OPERATION
9/13/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute Appendicitis | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 85 , to 9/22 , 19 85 , that (I) (we) last saw the deceased alive on 9/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
C. D. King / Laughlin DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
9/22/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KING / LAUGHLIN | | 22e. ADDRESS
Mercy Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-25-85 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. | | ADDRESS
1050 York Rd. Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 2 3 3
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|-------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CLARISSA BALL LAMB DIN | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 27 85 | | 2b. HOUR
8:50 a.m. | |
| 3. SEX
F | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
7 18 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Brewery | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Arbutus | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Ball | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella J. Whiteford | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
Unavailable | | 17. INFORMANT
ADDRESS
Francis X. Lambdin 4629 Wilkens Avenue 21229 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Brain Anoxia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Cardio Respiratory Arrest x 2**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Respiratory Failure and Renal Failure**

30 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Sepsis, Fluid overload, Possible interstitial nephritis, cellulitis

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/21 19 85 to 9/27 19 85 , that (I) (we) lost
saw the deceased alive on 9/27 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. Gordon | | DEGREE
MD | | 22c. DATE SIGNED
9/27/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. GORDON | | 22e. ADDRESS
St. Agnes Hosp 900 CATON Ave Balt Md. | | | |

| | | | | | |
|---|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
09-30-85 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery Baltimore | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | ADDRESS
4107 Wilkens Ave | | 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | |
| 25b. REGISTRAR'S SIGNATURE
G. J. Anderson | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. The funeral director should be given the certificate and the funeral permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

270073

100% COTTON



269053

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Leona MATILDA Lambert | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 18 1985 | | | 2b. HOUR
10 40 PM | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 24 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
Maryland A.A. | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4905 Brookwood Dr. Balt. MD 21225 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Kirby | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Thomas | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
219-01-5999 | | | 17. INFORMANT
Anna Moore | | | ADDRESS Glen Burnie, Md.
515 Hamlin Rd. 21061 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive heart failure | | | | | | | | weeks | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Renal failure | | | | | | | | years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypertension, atrial fibrillation | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-3 19 85 , to 7-18 19 85 , that (I) (we) lost
saw the deceased alive on 7-18 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Leonard M. Lamont | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9-18-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Leonard M. Lamont M.D. | | | 22e. ADDRESS
3001 S. Hanover St. Balt. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9-23-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery Brooklyn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
A.A. Md. | | |
| 24. FUNERAL DIRECTOR
McCully Funeral Home | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
Sylvia Davidson-Randall | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

289023

10 01 91232



COLLECTOR



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic events, the immediate coroner must be notified to go to the place of death.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|---|-----------------------|
| <div> <div> FOR
STATE
REGISTRAR </div> <div> REG. NO. </div> </div> | | | | | | | | | | |
| 1. DECEASED NAME
<div> <div>FIRST</div> <div>MIDDLE</div> <div>LAST</div> </div> ANNA J. LANASA | | | | | 2a. DATE OF DEATH
<div> MONTH DAY YEAR </div> Sept. 23, 1985 | | | | | 2b. HOUR
6:30 P.M. |
| 1. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
<div> MONTH DAY YEAR </div> April 8, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5003 Greenleaf Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sec./Treas. | | 12b. KIND OF BUSINESS OR INDUSTRY
A. Lanasa | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Fruit Co.
5003 Greenleaf Rd., 21210 | | |
| 14. FATHER'S NAME
<div> <div>FIRST</div> <div>MIDDLE</div> <div>LAST</div> </div> ANTONIA J. LANASA | | | | | 15. MOTHER'S MAIDEN NAME
<div> <div>FIRST</div> <div>MIDDLE</div> <div>LAST</div> </div> GIUSEPPA SANSONE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
215 10 5975 | | 17. INFORMANT
Mary Jane Schorr, Balto., MD | | 17. ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the gall bladder</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>Dec 16, 1984</u> to <u>Sept 23, 1985</u> , that (we) last saw the deceased alive on <u>Sept 16, 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (two) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Walter X. Welzant, M.D.</u> | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
<u>9/25/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Walter Welzant, MD | | | | | 22e. ADDRESS
6100 York Road, Balto., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/26/85 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 26 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>W. Davidson-Randall</u> | | | |

213063

1945, 1946

White

Female

U.S.

MD

8000 Greenleaf Road

Baltimore

Baltimore

MD

8000 Greenleaf Rd., 21110

Female

Classical

Female

MD

112 10 Ave Mary Lane, Baltimore, MD

MD

x

8100 York Road, Baltimore, MD

Dr. Walter Volz, MD

Female

1945

Low, Central

Baltimore

Henry W. Jenkins & Sons Co.

8100 York Road, Baltimore, MD 21110

MD

262116

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 2 3 6
CERTIFICATE OF DEATH

| | | | |
|--|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Francis L. Lang | | 2a. DATE OF DEATH MONTH DAY YEAR
9-10-85 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 7, 1908 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5501 Alban Ave (Residence) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Bartender | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
5501 Alban Avenue 21214 | |
| 13a. STATE
Maryland | | 13b. COUNTY | |
| 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John H. Lang | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna C. Kaehler | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-10-2345 | |
| 17. INFORMANT ADDRESS
Marquerite Cornes 3314 Chesley Ave. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (b).
DUE TO, OR AS A CONSEQUENCE OF (c).
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
CARCINOMA RIGHT LUNG | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER). | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2). | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPT. 20, 1973 to PRESENT , that (I) (we) lost saw the deceased alive on 7/30/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22a. SIGNATURE
Fausto Q. Aquino, Jr., M.D. | | 22c. DATE SIGNED
9-10-85 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Fausto Q. Aquino, Jr., M.D. | | 22e. ADDRESS
8713 Harford Rd. 21234 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Sep 13 1985 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME
Leonard J. Ruck, Inc. | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | |

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER



Manufactured by...

...

...

260059

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Leopold Laniewski | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 12, 1985 | | 2b. HOUR
2:05AM | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4-18-12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Harbor Sales | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2032 Eastern Ave./21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Laniewski | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Phillips | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W-4-11 212-01-0340 | |
| 17. INFORMANT
ADDRESS
Irene Laniewski 2032 Eastern Ave. 21231 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cancer of the Colon
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 14, 1985 to September 12, 1985 at (I) (we) last saw the deceased alive on September 12, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James J. Hannigan | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9-12-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler Inc. | | ADDRESS
1901 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
John W. Anderson | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified of office.

BP

020005

100% COTTON FIBER

DAVID

WALKER



270101

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25238
REG. NO.

| | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|--------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | X MONTH DAY YEAR | | 2b. HOUR | |
| Michael | | Lapinski | | | | | | 9/ 20/ 19 85 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD | | 1:00 | |
| Male | White | Nov. 28 1943 | | 41 YRS. | | | | | | 9/ 20/ 19 85 | | A M | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | USA | | | | Baltimore City, | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | |
| Baltimore | | Francis Scott Key Medical Center | | Crown Cork & Seal | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? | | | | 13b. STREET ADDRESS | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 400 Meadow Rd. 21206 | | | | | |
| Md. | | Baltimore | | Parkville | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | |
| Henry | | Lapinski | | Elizabeth | | Diven | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| | | 212-42-1245 | | Emma Ruble | | 8118 Gray Haven Rd. 21222 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): <u>Calcific aortic stenosis</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c): | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Insection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED 9/20/85 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| Burial | | | | 9/23/85 | | | | Parkwood Cemetery | | | | | |
| 23d. LOCATION
CITY OR TOWN | | | | COUNTY | | | | STATE | | | | | |
| Parkwood | | | | Baltimore | | | | Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Connolly Funeral Home 300 Mace Ave. 21221 | | | | SEP 25 1985 | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

SEP 25 1985

RECEIVED

1000

1000



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259137

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JERRY LATOS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 9, 1985 | | 2b. HOUR
6:40P
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4 18 98 | 6. AGE (IN YEARS LAST BIRTHDAY)
87
YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2429 Eastern Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seaman | 12b. KIND OF BUSINESS OR INDUSTRY
Maritime | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2429 Eastern Avenue 21224 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Spiro Latos | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Tasoula Papanastasiou | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 230-26-2345A | | 17. INFORMANT ADDRESS
Spear A. N. Latos
2429 Eastern Avenue, Baltimore, Md. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hepatocellular carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min
1 month |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Esophageal Varices</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/5</u> , 19 <u>85</u> , to <u>8/80</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>8/20/</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>David M. Hockenbery</u> | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>9/11/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David M. Hockenbery | | 22e. ADDRESS
Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-12-85 | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Ann Matthews, Matthews Funeral Home
3021 Eastern Avenue, Baltimore, Md. 21224 | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

9
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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and entered in the death record, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified at once.

781825



264103

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25240

| | | | | | |
|---|---|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) Crea Lawrence | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 17 85 | | 2b HOUR
435 AM |
| 3 SEX
Female | 4 RACE
Black | 5 DATE OF BIRTH
MONTH DAY YEAR
02-7-1900 | | 6 AGE (IN YEARS LAST BIRTHDAY)
85 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
85 YRS |
| 7a BIRTHPLACE
(COUNTRY)
NORTH CAROLINA | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Balti city MD | |
| 10 CITY OR TOWN OF DEATH
BARTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hutcheson Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
MARYLAND | | 13b COUNTY
BARTIMORE | 13c CITY OR TOWN
BARTIMORE | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE
3803 FERNDALE AVE |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
GEORGE | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERNICE Scott | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
224-09-7871 | | 17 INFORMANT ADDRESS
Dorothy BARMER 3803 FERNDALE AVE | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Accident | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) CARDIAC ARREST | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 9/16 19 85 to 9/17 19 85 that (I) (we) last saw the deceased alive on 9/17 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Ambachew Woreta | | DEGREE
MD | | 22c DATE SIGNED
9/17/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
AMBACHEN WORETA | | 22e ADDRESS
9233 WINDING WAY ELICOT CITY | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b DATE
9-21-85 | 23c NAME OF CEMETERY OR CREMATORY
CEDARHILL CEM | | 23d LOCATION
CITY OR TOWN COUNTY STATE
BARTIMORE MARYLAND | |
| 24 FUNERAL DIRECTOR
NAME
BROWN THOMPSON F.H. | | ADDRESS
1913 W. BALTO. ST | | 25a DATE REC'D. BY REGISTRAR
SEP 18 1985 | 25b REGISTRAR'S SIGNATURE
[Signature] |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 x COTTON LINED

20 x COTTON LINED



2601043

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 7 5 2 5 2 4 1 | |
|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | |
| REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM THOMAS LAWSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 9, 1985 | | 2b. HOUR
A
8:01 | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 17 38 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
47 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS | | 8. IF UNDER 24 HRS.
HOURS MIN.
MD. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN)
VIRGINIA | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | |
| 12. CITY OR TOWN OF DEATH
BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MD. | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
MARYLAND | | 15b. CITY OR TOWN
BALTIMORE | | 15c. STREET ADDRESS / ZIP CODE
2513 E. MADISON ST. 21205 | | |
| 16. FATHER'S NAME
FIRST MIDDLE LAST
CHARLIE LAWSON | | 17. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALBERTA BRANDON | | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 18b. SOCIAL SECURITY NO.
217-34-9206 | | 18c. INFORMANT ADDRESS
MARTHA LAWSON 2513 E. MADISON ST. | | |
| 19. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pneumonia / Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Lung Cancer | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
24 hrs
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) this hospital attended the deceased from Sept 9, 19 85 to Sept 9, 19 85 , that (1) (we) last saw the deceased alive on Sept 9, 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Elaine C. Hefty MD | | | | | 22c. DATE SIGNED
9/9/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELAINE C. HEFTY | | | | | 22e. ADDRESS
600 N. Wolfe St., Baltimore, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
9/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Gale Davidson-Randall | | |

101008

RECEIVED

NOTICE

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260012

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ALFRED MADISON LEE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 12, 1985 | | 2b. HOUR
3:45 A.M. |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 2 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5022 E. OLIVER ST. 21205 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY
GLENN L. MARTIN |
| 13a. STATE
MD. | | | 13b. COUNTY
- | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT E. LEA | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLA LANNINGHAM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
231-18-0236 | | 17. INFORMANT
ADDRESS
149 E. KING ST. LITTLESTOWN, PA. 17340 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio-respiratory arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced carcinoma of rectum</i>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION
2/9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5 19 85 , to 9/13 19 85 , that (I) (we) lost
saw the deceased alive on 9/13 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>S. Weiner</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9-13-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Seymour Weiner | | 22e. ADDRESS
Franklin Square Drive | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/14/85 | 23c. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE MEM. PARK | | 23d. LOCATION
CITY OR TOWN COUNTY
BALTIMORE MD. | |
| 24. FUNERAL HOME
SCHIMONEK FUNERAL HOME, INC.
3331 Brehms Lane, Balto. Md. 21213 | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>W. A. Anderson</i> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to the funeral director. The funeral director should be notified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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| | | | | | | | | | |
|---|--|---|--|--|---|---|--------------------------------|--|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
| FOR
1- STATE REGISTRAR | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DAVID F. LEE | | | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 26 85 | | 2b HOUR
4:15a M | | |
| 3 SEX
M | | 4 RACE
B | | 5 DATE OF BIRTH
MONTH DAY YEAR
10 14 22 | | 6 AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Virginia | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VETERANS ADMINISTRATION MEDICAL CENTER | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b COUNTY | | 13c. CITY OR TOWN
Baltimore | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Crosky Bell | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Braxton | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
223204736 | | 17 DECEASED ADDRESS
Frances McDowell 3004 E. Federal Street
VAMC 3900 LOCH RAVEN BLVD BALTO, MD 21218 | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Squamous cell cancer of the esophagus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Approximate interval between onset and death
<u>2 days</u>
<u>1 year</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (X) (this hospital) attended the deceased from <u>AUGUST 29</u> , 19 <u>85</u> , to <u>SEPTEMBER 29</u> , 19 <u>85</u> , that (X) (we) lost saw the deceased alive on <u>SEPTEMBER 29</u> , 19 <u>85</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<u>Allen L. Dollar</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED
<u>9/26/85</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Allen L. Dollar, M.D.</u> | | | | 22e ADDRESS
<u>3900 LOCH RAVEN BLVD BALTO, MD 21218</u> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b DATE
<u>10-1-85</u> | | 23c NAME OF CEMETERY OR CREMATORY
<u>Pinelawn Cemetery</u> | | 23d LOCATION
CITY OR TOWN COUNTY STATE
<u>Anne Arundal Md.</u> | | | |
| 24 FUNERAL DIRECTOR
NAME
<u>W.C. March F/H Co. 1101 E. North Ave.</u> | | | | 25a DATE REC'D. BY REGISTRAR
<u>SEP 30 1985</u> | | 25b REGISTRAR'S SIGNATURE
<u>W.C. March</u> | | | |

2/10/75

20% COTTON FIBER

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260067

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Edward W Lee | | | 2a. DATE OF DEATH
MONTH 9 DAY 8 YEAR 85 | | | 2b. HOUR
6:35 M | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH 9 DAY 11 YEAR 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FSK Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | |
| 13a. STATE
md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2000 O'Dell Ave. Apt. 1503 | | | | 13f. ZIP CODE
21237 | | | |
| 14. FATHER'S NAME
PHILLIP LEE | | | | 15. MOTHER'S MAIDEN NAME
MINNIE BOYD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
215-01-6203 | | 17. INFORMANT
JEANNE LEE | | | |
| | | | | ADDRESS
808 GLENWOOD Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory / cardiac arrest | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) bilateral lower extremity gangrene | | | | | | | 2. |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
non-resectable lung CA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-6-85 , 19 85 , to 9-8 , 19 85 , that (I) (we) lost
saw the deceased alive on 9-8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Howard Tuch | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9-8-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Howard Tuch | | | | 22e. ADDRESS
FSK Hospital Baltimore Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Rendell | |

MEDICAL CERTIFICATION

9
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 also be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

259116

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT A. LEE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 5 85 | | 2b. HOUR
M
7 A | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 - 01 - 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
87 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman Lee | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amanda Winder | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
218-10-5483 | | 17. INFORMANT
ADDRESS
Catherine Lee 5327 Cuthbert Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF:
(b) CONGESTIVE HEART FAILURE | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(c) CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/6/85 to 9/5/85 , that I (we) lost
saw the deceased alive on 9/5/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Ambrose Woreta MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/5/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AMBROSE WORETA | | | | 22e. ADDRESS
9233 Winding Way Ellicott City MD 21047 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/9/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Memorial PK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
SEP 11 1985 <i>[Signature]</i> | | | | |

BP

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270023

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|------------------------------|
| 1. FOR STATE REGISTRAR | | 5 2 5 2 4 6
REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<u>Stephen Louis Lee, Jr.</u> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>9 22 85</u> | | | | 2b. HOUR
<u>9:12 P.M.</u> |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>Black</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>4 3 85</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<u>5 19</u> | | 7. # UNDER 1 YEAR
UNDER 24 HRS.
HOURS MIN.
<u>5 19</u> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Sinai Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Baby</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<u>Maryland</u> | | | | | | 13b. COUNTY
<u>USA</u> | | 13c. CITY OR TOWN
<u>Baltimore</u> | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET ADDRESS / ZIP CODE
<u>1309 Poplar Grove St 21216</u> | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Stephen Louis Lee</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Shawnee Crockett</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>N/A</u> | | 17. INFORMANT
<u>Shawnee Crockett</u> | | ADDRESS
<u>1309 Poplar Grove St</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { (b) <u>Purulent Pericarditis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Sepsis (presumed H. flu).</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 22, 1985</u> , to <u>Sept 22, 1985</u> , that (I) (we) last saw the deceased alive on <u>Sept 22, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Margaret M. Nichols</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<u>9/23/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Margaret M. Nichols M.D.</u> | | | | 22e. ADDRESS
<u>Sinai Hospital / Dept of Pediatrics</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>9/26/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cem</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Anne Arundel Co., Md.</u> | | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Wm C March F/H, Inc. West</u> | | | | ADDRESS
<u>4300 Wabash Ave</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>SEP 25 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

550053

1



RECEIVED

RECEIVED

RECEIVED

RECEIVED

1968 CR 536

246026

FOR
1- STATE 9-13-85 D.W.
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 2 4 1

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) VALARIE Michelle Lee | | | 2a. DATE OF DEATH
MONTH DAY YEAR
8-26-85 | | | 2b. HOUR
1:15 PM | | | | |
| 3 SEX
FEMALE | | 4 RACE
BLK. | | 5. DATE OF BIRTH
MONTH DAY YEAR
11-20-54 | | 6. AGE (IN YEARS LAST BIRTHDAY)
30 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. STATE
MD | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lawrence Ferguson | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fowlkes Myrna | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
213-62-0137 | | | 17. INFORMANT
ADDRESS
Myrna E. Johnson, 1904 N. Longwood St. | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
9289 Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF:
Branstem Dysfunction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF:
Sepsis + Pneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | |
| 19a. DATE OF OPERATION
7/30/85 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Posterior Fossa Hematoma | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
7131 8/26 85 | | 21g. DATE SIGNED
8/26/85 | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/31 , 19 85 , to 8/26 , 19 85 , that (I) (we) last saw the deceased alive on 8/26 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22a. SIGNATURE
Robert B. Brummerman | | | DEGREE | | | 22c. DATE SIGNED
8/26/85 | | | 22b. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BURGERMAN MD | | | 22e. ADDRESS
UNIVERSITY of MD HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
8/31/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore County | | | |
| 24. FUNERAL DIRECTOR'S NAME
Funeral Home & Sons | | | | | | 24b. DATE REC'D. BY REGISTRAR
AUG 29 1985 | | 24c. REGISTRAR'S SIGNATURE
Davidson-Randall | | |
| 25. FUNERAL HOME ADDRESS
2501 Gwynns Falls Parkway | | | | | | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21a marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

8-25-82

30

11-25-82

X

U.S.A.

A. 2.0

Delaware University Hospital

MD Baltimore City X

Carroll County, Md

Lawrence

40

Cardiac Arrest

Ischemic Heart Disease

11

Supine + Prone

Posterior-inferior

11

I

8/50 82

3131

412

Y - 40K2

Black (Brown hair)

BLACK 3-4-7 MD - NURSES 11 4-10 10-11-82

261010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 2 4 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM LEEBRICK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-8-85 | | 2b. HOUR
M. |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
2-26-1897 | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
422 N. LUZERNE AVE. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BARBER | | 12b. KIND OF BUSINESS OR INDUSTRY
BARBERING |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
— | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES L. LEEBRICK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NENA WOODY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
231-07-6059 | | 17. INFORMANT
ADDRESS
Mrs. Theresa M. Sage - 422 N. Luzerne Ave. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Unknown | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Roy Verdery | | DEGREE
no | | 22c. DATE SIGNED
9/10/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROY VERDERY | | 22e. ADDRESS
BEAUMONT CENTER EASTERN AVE BAL MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9-11-85 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER CEM | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME
Hartley Miller - 2334 Jefferson St | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

28-B-P

SS

(P3) - 2.5

W

M

28-B-P

W

M

28-B-P

28-B-P

28-B-P

28-B-P

X

28-B-P

28-B-P

28-B-P

28-B-P

28-B-P

28-B-P

28-B-P

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as being a death from injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|-------------------------------|---|----------------------------|--|---|
| <div> <div>261009</div> <div>1. STATE REGISTRAR</div> </div> <div> <div>REG. NO.</div> <div>8 5 2 5 2 4 9</div> </div> | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | A |
| MELANIE R. LEESON | | | | | SEPTEMBER 10, 1985 | | 1:35 | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| F | | W | | 9-28-1974 | | 10 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | JOHNS HOPKINS HOSPITAL | | | | SCHOOL | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? |
| MD. | | | | | - | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| PHILIP E. LEESON, JR. | | | | | JOANN T. TULLY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 215-92-2314 | | Mrs. Hilda B. Leeson - 3056 Stafford Rd. 21223 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I: DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest.</u> | | | | | | | | 10 MINUTES | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | 1 YEAR | |
| (b) <u>Terminal cystic Fibrosis</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/27, 1985, to 9/10, 1985, that (I) (we) last saw the deceased alive on 9/10 1:35 AM 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | 22c. DATE SIGNED | | |
| Linda Solow MD. | | | | | | | 9/10/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| Linda Solow MD. | | | | | Johns Hopkins Hospital. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | STATE | |
| BURIAL | | 9-13-85 | | DEVID RIDGE Cem. | | BALTO., MD. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Dorothy Miller - 2334 Jefferson St. | | | | | SEP 11 1985 | | Julia Davidson-Randall | | |

1000



MINIATURE

100% COOL

[Faint, mostly illegible text and markings covering the page, including what appears to be a date '1-13-32' and various handwritten notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

256063

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 2 5 0

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ALVAH J. LEISTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 7 85 | | 2b. HOUR
P.M.
1:00 |
| 3 SEX
Male | 4 RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
11 08 93 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3646 Elm Avenue 21211 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Renovator | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Employ. |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John S. Leister | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Reed | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes W.W.1 | | 16b. SOCIAL SECURITY NO.
214-01-3830 | | 17. HOME ADDRESS
Pikesville, Maryland 21208
Flora Leister 7526 Seven Mile Lane | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1982 19____, to 1985 19____, that (I) (we) last saw the deceased alive on 1984 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE
Richard L. Diamond | | | | 22c. DATE SIGNED
9-7-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD L DIAMOND | | | | 22e. ADDRESS
3547 Chestnut Ave Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/9/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Park | |
| 24 FUNERAL DIRECTOR
NAME
Raymond C. Fink | | 24b. ADDRESS
Glen Burnie, Md. 21061 | | 25a. C.D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
SEP 9 1985 | |

MEDICAL CERTIFICATION

52063

269084

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

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|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DONNA ANN LEMMERMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/ 19/ 85 | | 2b. HOUR PM
9:15 M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 18 53 | | 6. AGE (IN YEARS LAST BIRTHDAY)
32 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Senior Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
John Hancock Ins. |
| 13a. STATE
Maryland | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
1803 Saunders Way 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Donald E. Herrmann | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances A. Klein | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO
Unavailable | | 17. INFORMANT
Timothy F. Lemmerman 1803 Saunders Way 21061 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL ANOXIA / NECROSIS 9 DAYS
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) RESPIRATORY ARREST 9 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c) SOFT TISSUE HEMORRHAGE AT PERIOPERATIVE SITE 9 DAYS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
CERVICAL SPONDYLOSIS C4-C5 | | | | | |
| 19a. DATE OF OPERATION
9/11/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
cervical spondylosis | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from Sept 10, 19 85, to Sept 19, 19 85, that (we) last saw the deceased alive on Sept 19, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bert F. Morton M.D. | | 22c. DATE SIGNED | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Bert F. Morton, M.D. | | 22f. ADDRESS
St. Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 23e. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
SEP 24 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

200000



THE
OFFICE
OF THE
SECRETARY
OF THE
NAVY
WASHINGTON
D. C.
20540

1. The Secretary of the Navy is hereby notified that the following information has been received from the Bureau of Naval Affairs:

2. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

3. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

4. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

5. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

6. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

7. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

8. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

9. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

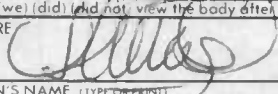
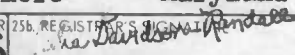
10. The Bureau of Naval Affairs has received information from the Bureau of Naval Affairs that the following information has been received from the Bureau of Naval Affairs:

262120

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 5 2 5 2 5 2

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNA R LEONARD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09 15 85 | | | 2b. HOUR
9:40 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
09 20 90 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5779 EDGE PARK RD. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George C. Rammes | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Not Known | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
212-74-4590 | | | 17. INFORMANT ADDRESS
Margaret L. Bunce 5779 Edgemark Rd. 21239 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) REFRACTORY CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 08/12/85 , 19 85 , to 09/15 , 19 85 , that (I) (we) last saw the deceased alive on 09/15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
 | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/15/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CESAR M PEÑA | | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Sep 18 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 5 2 5 2 5 3

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY V. LERCH | | | 2a. DATE OF DEATH MONTH DAY YEAR
9 8 85 | | | 2b. HOUR
9:30 P M | |
| 3 SEX
FELMAN | | 4 RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 26 00 | | 6 AGE (IN YEARS LAST BIRTHDAY)
84
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UNKNOWN Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | |
| 10 CITY OR TOWN OF DEATH
City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Lady-Bookstore | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
George Lerch | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sally Cook | | 13e. STREET ADDRESS / ZIP CODE
333 HARLEM LAVE - 21228 #29 | | 8 Cromarty Rd | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-01-1191 | | 17 INFORMANT
Marvin Reeser | | ADDRESS
1009 Collwood Rd.-Balto., Md.
#21228 | |

II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CANCER OF RIGHT BREAST

DUE TO, OR AS A CONSEQUENCE OF

(b) METASTASIS

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

DEHYDRATION

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

URINARY TRACT INFECTION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/21, 19 85, to 9/8, 19 85, that (I) (we) lost
saw the deceased alive on 9/8, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Ambachew Woreta MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/8/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AMBACHEW WORETA | | 22e. ADDRESS
9233 WINDING WAY ELLICOTT CITY, Md | | | | | |

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|--|--|-------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-11-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Pk. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Balto. Md. | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab | | 5151 Balto. Nat'l. Pike | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to Baltimore. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CHARLES B LETBETTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 7, 1985 | | 2b. HOUR
P M
4:15 P |
| 3. SEX
male | 4. RACE
Negro | 5. DATE OF BIRTH
MONTH DAY YEAR
2 15 09 | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YRS.)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1810 N. Bond Street 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Horace Letbetter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY BIVINS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
239-01-5314 | 17. INFORMANT
ADDRESS
Alice Letbetter 1810 N. Bond St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Multiple Myeloma
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 minutes
2 YEARS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/2 , 19 85 , to 9/7 , 19 85 , that (2) (we) last saw the deceased alive on 9/7/85 , 19 85 , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
L. N. DuBois | | DEGREE
MD | | 22c. DATE SIGNED
9/7/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. N. DuBois | | 22e. ADDRESS
Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9/13/85 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel County | | |
| 24. FUNERAL DIRECTOR
NAME
Calvin B. Scraggs | | ADDRESS
1412 E. Preston St. | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Gail Davidson-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

524110

20% CATION LEEB

WINTER



275099

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 2 5 5

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SALVATORE J LETO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 27, 1985 | | 2b. HOUR
2:14a M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 15, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS
IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. Va. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance Mech. | | 12b. KIND OF BUSINESS OR INDUSTRY
Lever Bros. |
| 13a. STATE
Md. | | | 13b. COUNTY
Baltimore | 13c. STREET ADDRESS / ZIP CODE
5509 Knell Avenue 21206 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Saverio Leto | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pauline Pecora | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
yes WW 2 | | 16b. SOCIAL SECURITY NO.
219-07-1749 | | 17. INFORMANT ADDRESS
Mrs. Mary Collini 5539 Plainfield Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (c) Bladder Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
~ 3 days
4 weeks
3 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | |
| 19a. DATE OF OPERATION
8/16/85 / 8/27/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bladder Carcinoma / Sepsis | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/17 , 19 85 , to 9/27 , 19 85 , that (I) (we) lost
saw the deceased alive on 8/27 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Warren R. Maley MD | | | | 22c. DATE SIGNED
9/27/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WARREN R. MALEY | | | | 22e. ADDRESS
Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Oct. 1, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck Inc. Baltimore, Maryland | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | | 25b. REGISTRAR'S SIGNATURE
Lia Davidson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 2 5 6

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ANNA MAE LEUTNER | | | 2a. DATE OF DEATH MONTH DAY YEAR
September 04 1985 | | 2b. HOUR
4:05P M |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
06 12 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
79 YRS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MARYLAND | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
CATONSVILLE | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1024 CRAFTSWOOD ROAD 21228 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
MARTIN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNABELLE CRATZ | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
714-05-6882 | | 17. INFORMANT ADDRESS
WALTER LEUTNER 1024 CRAFTSWOOD ROAD 21228 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*cardiopulmonary arrest*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

renal failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

dehydration

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

CUP

MEDICAL CERTIFICATION

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Dr. Al Maciulis</i> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. AL MACIULIS | | 22e. ADDRESS
ST. AGNES HOSPITAL | |

| | | | |
|--|----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
SEPT 4, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC | | ADDRESS
4107 WILKENS AVENUE | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
SEP 6 1985 <i>John Davidson-Randall</i> |

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1962-1963

1962-1963

1962-1963

1962-1963

1962-1963

1962-1963



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2525 ✓
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|--|---------------------|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CLINTON | | FIRST
MIDDLE
LAST
LEWIS | | 2a. DATE KNOWN OF DEATH
ESTIMATED
9 5 1985 | | 2b. HOUR
M
12:22 A | |
| 3. SEX
Male | 4. RACE
Am. Ind. | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 26, 1920 | 6. AGE (IN YEARS)
LAST BIRTHDAY
65 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
9 5 1985 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2022 E. Pratt St. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Construction work | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Pink Lewis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Abigail Hammonds | | 13e. STREET ADDRESS
2022 E. Pratt Street 21231 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
243-12-0161 | | 17. INFORMANT
ADDRESS
Mrs Lewis 2022 E. Pratt Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
9-5-85 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-8-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant View | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fairmont Robeson N.C. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
John M. Weber & Sons Inc. 401 S. Chester St. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 6 1985 | | 25b. REGISTRAR'S SIGNATURE
 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

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RECEIVED
JAN 10 1971
U.S. AIR FORCE

RECEIVED
JAN 10 1971
U.S. AIR FORCE

253123

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25258
926200

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 9 3 85 | | 11 PM | |
| Eva Eva Lewis | | Lewis | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| F | | Cauc | | 21/6/07 | | 78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | | USA | | | | BALTIMORE City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Francis Scott Key Hospital | | Retired | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | | |
| 13a. STATE COUNTY | | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21224 | | | |
| MARYLAND | | BALTIMORE | | 216 S. CLINTON STREET | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| 14. FIRST MIDDLE LAST | | 15. FIRST MIDDLE LAST | | no | | 21237 | |
| Michael Kane | | Josephine Price | | | | | |
| 17. INFORMANT | | ADDRESS | | 21237 | | | |
| G. Glyn Lewis | | 8203 Edwill Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) APNEA | | 5 MIN | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT | | 30 DAYS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | NONE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (did) (did not) view the body after death | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| 9/3/85 to 9/3/85 | | CR Kennedy MBBS MRCP(UK) | | 9/4/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | |
| KENNEDY | | Francis Scott Key Hospital | | SEP 6 1985 | | Julia Davidson-Randall | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 9/7/85 | | Sacred Heart Cem. | | Baltimore Md | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Lilly & Zeiler Inc. 700 S. Conkling St. | | SEP 6 1985 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corroborative pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHAMBER

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Religious from station hospital

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270021

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
GERALDINE LEWIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 22, 1985 | | 2b. HOUR
2:44P M | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 29 36 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49
YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES XX NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Poindexter Newton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth E. Anderson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216-34-3335 | | 17. INFORMANT
ADDRESS
William C. Lewis 3438 Dolfield Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Severe anemia and hypovolemia
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (X) this hospital attended the deceased from September 16, 1985 to September 22, 1985 , that (X) (we) last saw the deceased alive on September 22, 1985 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Robert J. Chapolini | | DEGREE
M.D. | | 22c. DATE SIGNED
9/22/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT J. CHAPOLINI | | 22e. ADDRESS
c/o Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/27/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md | | 23e. DATE REC'D. BY REGISTRAR
SEP 25 1985 | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H 4300 Wabash Avenue | | 25. REGISTRAR'S SIGNATURE
Sasha Davidson-Randall | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 10 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 2 6 0

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jean E. Lewis | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/28/85 | | | 2b. HOUR
10 P.M. | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 7 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Delaware | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1101 St. Paul St. Apt. 810 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
State of Md. | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1101 St. Paul St. Apt. 810 21202 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George L. Mason | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
221-12-6039 | | 17. INFORMANT
ADDRESS
William J. Lewis (same address) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>Proximal & HCLD</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 min</u>
<u>2 hr</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/26</u> , 19 <u>85</u> , to <u>9/28</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Norman R. Freeman MD</u> | | | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
9/30/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmuont | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | |
| 24. FUNERAL HOME
NAME ADDRESS
Schmunk Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |

SEP 30 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1-
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 2 6 1

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY None LEWIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 5 85 | | 2b. HOUR
7:45 PM |
| 3 SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
11 06 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MD HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. COUNTY
BALT CITY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
811 WHITE LOCK ST 21217 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JERRY WASHINGTON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LOTTIE WYMER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
217-26-1135 | | 17. INFORMANT
ADDRESS
Robert Lewis 5420 Creamer Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPSIS OR INFECTION
DUE TO, OR AS A CONSEQUENCE OF
(c) ADENOCARCINOMA OF LUNG | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
METASTATIC DISEASE, UNCONTROLLED DIABETES | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11:30 AM 9/5 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (his hospital) attended the deceased 11:30 AM 9/5 1985 to 7:45 PM 9/5 1985 that (I) (we) lost
saw the deceased alive on 7:45 PM 9/5 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
David A. Flick | | DEGREE
MD | | 22c. DATE SIGNED
9/5/85 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID A. FLICK | | 22e. ADDRESS
UNIV. OF MD HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | 23b. DATE
9-10-85 | 23c. NAME OF CEMETERY OR CREMATORY
Greenbury Mem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. |
| 24. FUNERAL DIRECTOR
NAME
Keray O. Wyeth | | 25a. DATE REC'D BY REGISTRAR
SEP 19 1985 | | 25b. SIGNATURE OF REGISTRAR
[Signature] | |

MEDICAL CERTIFICATION

29

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 4 should be filed within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

269155

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RICHARD W LEWIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 14, 1985 | | 2b. HOUR
12:15a M |
| 3. SEX
MALE | 4. RACE
CAUC. | 5. DATE OF BIRTH
MONTH DAY YEAR
4-1-1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ANALYST | 12b. KIND OF BUSINESS OR INDUSTRY
NSA. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MARYLAND | 13b. COUNTY
ANNE ARUN. | 13c. CITY OR TOWN
SEV. PK. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
70 RIVERSIDE DR. MD 21146 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE W. LEWIS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LUCILLE W. LEWIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b. SOCIAL SECURITY NO.
WW II 246185906 | 17. INFORMANT ADDRESS
LAURA LEWIS (SAME AS ABAB #13P) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) CANDIDA TROPICALIS SEPTICEMIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYELOGENOUS LEUKEMIA. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
3 weeks
2 months |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19 19 85 to 9/14 19 85, that (I) (we) last saw the deceased alive on 9/14 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (I) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Alexander Hantel</i> | | DEGREE | | 22c. DATE SIGNED
9/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALEXANDER HANTEL MD | | 22e. ADDRESS
600 N. WOLFE ST BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9-17-85 | 23c. NAME OF CEMETERY OR CREMATORY
MD. VET. CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CROWNSVILLE, AA. MD | |
| 24. FUNERAL DIRECTOR
NAME
BARRANCO FUNERAL Hm. | | 25. DATE RECD. BY REGISTRAR
P 18 1985 | | | |
| 26. REGISTRAR'S SIGNATURE
<i>John B. ...</i> | | 27. REGISTRAR'S NAME
21146 | | | |

580122

DATE 0600
4-1-1955
North Atlantic USA

ASST
Tspara

AMERICAN AIR FORCE 251 K

WILLIE 24183000 Laura Lewis



1 02 22 LIS

PARISH 8-12-55 MONT 251 K
BARRING FURNITURE CO. SEVENA ROAD
251 K

254072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARIA J. LIADAKIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 5, 1985 | | 2b. HOUR
7:10A _M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
6 12 35 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | 7b. CITIZEN OF WHAT COUNTRY?
Greece | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
6735 Youngstown Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Restaurateur | 12b. KIND OF BUSINESS OR INDUSTRY
Food | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
6735 Youngstown Avenue 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Antonios Fotinos | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Irene Kalogeros | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216-80-2959 | | 17. INFORMANT
John Liadakis, 6735 Youngstown Avenue
Baltimore, Md. 21222 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Breast carcinoma</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|----------------|--|
| 22b. SIGNATURE
<i>Richard J. Jones</i> | DEGREE
M.D. | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard J. Jones | | 22e. ADDRESS
Johns Hopkins Oncology Center Bldg. M.D. |

| | | | |
|---|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-7-85 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. |
| 24. FUNERAL DIRECTOR
Ann S. Matthews, Matthews Funeral Home
3021 Eastern Avenue, Baltimore, Md. 21224 | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

MEDICAL CERTIFICATION

97
20
35
177

9
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

35025

259193

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. PAGE 5 SHOULD BE FILED WITHIN 72 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25264

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|-------------------------|--|--|---|---|---|---|---|-------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
JUNIOR Fillmore LILLER | | | 2a. DATE OF DEATH
KNOWN ESTI-
MATED <input checked="" type="checkbox"/> 9-10-85
<input type="checkbox"/> 19 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 3 1919 | 6. AGE (IN YEARS)
LAST BIRTHDAY
66 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE
PRONOUNCED DEAD
9-10-85
19 | | | 2d. HOUR
4:21P
M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Keyser, W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
Francis Scott Key Med. Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Grinder | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel Mfg. | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Baltimore | | 13c. CITY OR TOWN
Essex | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
9 Branch St. 21221 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Guy F. Liller | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah A. Nash | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
233 05 9737 | | 17. INFORMANT
ADDRESS
Mary C. Liller, Wife | | | Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | ADDRESS
111 Penn Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
Burial | | | 23b. DATE
9/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co., Md. | |
| 24. FUNERAL DIRECTOR
<i>Prudzinski</i> | | | | | 25a. THE REGD. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Prudzinski</i> | | |
| 26. FUNERAL HOME
Prudzinski Funeral Home PA 1407 Old Eastern Ave | | | | | | | | | |

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

223193 NOTED 2/20/71



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

25203
26. DATE OF DEATH ☒ KNOWN ☐ ESTIMATED **9-20-85**
27. DATE PRONOUNCED DEAD **9-20-85**
28. HOUR **7:24**

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
RUTH N. LILLY

3. SEX **Female** 4. RACE **White** 5. DATE OF BIRTH MONTH DAY YEAR **8 31 23** 6. AGE (IN YEARS LAST BIRTHDAY) **62** 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **West Virginia** 7b. CITIZEN OF WHAT COUNTRY? **USA** 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH **Baltimore City** MD.

10. CITY OR TOWN OF DEATH **Baltimore** 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION **3606 Paine Street 21211**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Waitress** 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE **Maryland** 13b. CITY OR TOWN **Baltimore** 13c. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS **3606 Paine Street 21211**

14. FATHER'S NAME FIRST MIDDLE LAST **Homer Nicola** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Dove Poling**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **No** (IF YES, GIVE WAR OR DATES) **--** 16b. SOCIAL SECURITY NO. **220-14-6885**

17. INFORMANT ADDRESS **Elnora Lilly 3606 Paine Street 21211**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Arteriosclerotic cardiovascular disease**
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) **obesity**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

obesity

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Margarita A. Korell**

TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **9-20-85**

EXAMINER'S NAME (TYPE OR PRINT) **Margarita A. Korell, M.D.** ADDRESS **111 Penn Street**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial**

23b. DATE **9/24/85**

23c. NAME OF CEMETERY OR CREMATORY **Meadowridge Mem. Park**

23d. LOCATION CITY OR TOWN COUNTY STATE **Baltimore Maryland**

24. FUNERAL DIRECTOR NAME ADDRESS **A. Alan Seitz, Jr. 3818 Roland Ave. 21211**

25a. DATE REC'D. BY REGISTRAR **SEP 23 1985**

25b. REGISTRAR'S SIGNATURE **Shelia Davidson-Randall**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRESENT ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

101835

20% COTTON FIBER

WATKINS



256045

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25260
REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|---|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | |
| RAYMOND G. LINDEMANN | | | | | | | | 9 5 19 85 | | | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| MALE | WHITE | OCT. 31 1946 | | 38 YRS. | | | | | | 9 5 19 85 | | | | | | 7:25 AM | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| MARYLAND | | U. S. A. | | | | Baltimore City | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | South Balto. Gen. Hosp. | | ELECTRICIAN | | GOV'T | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 635 S. STREEPER ST. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| ADOLPH LINDEMANN | | HELEN CHOTMACKA | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| YES | | NAVY | | | | ADEKE OGRZEWSKI 920 S. CURLEY ST. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | 9-5-85 | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | M.D. Assistant | | MEDICAL EXAMINER | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | 111 Penn St., Balto., MD | | 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| BURIAL | | SEPT. 9 1985 | | ST. STANISLAUS CEMETERY | | BALTIMORE | | BALTIMORE | | MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| RAYMOND H. KACZOROWSKI | | 12525 FLEET ST. | | SEP 10 1985 | | Ann M. Dixon - Randall | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETURN PAGE 4 WITH YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP 1307
DHMH - 17
(VR A15 ME (5))

322042

2022 COLIC 1383

OWO

WAVE



266075

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ruth E. Lipka | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 16, 1985 | | 2b. HOUR
9:00 PM | |
| 3 SEX
FEMALE | | 4 RACE
CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 27 18 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | |
| 10 CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOSPITAL | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. STREET ADDRESS / ZIP CODE
3336 E BALTIMORE ST 21224 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
George Washington Thomas King Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Viola E. Dell's | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
212-14-1155A | | 17. INFORMANT
ANTHONY LIPKA | | 17. ADDRESS
3336 E BALTIMORE ST 21224 | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Ruptured Aortic Aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(c) Ruptured Aortic Aneurysm | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Exairesis Abdominal Aneurysm | | | | | |
| 19a. DATE OF OPERATION
September 14, 1985 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
XXXXX | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 13-85 to September 16-85, that (I) (we) last saw the deceased alive on September 16-85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Kaczorowski | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Polish Nat'l | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | 24 FUNERAL DIRECTOR
NAME
KACZOROWSKI | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | |
| 24. ADDRESS
FUNERAL HOME 3525 Fleet St. | | 25b. REGISTRAR'S SIGNATURE
Kaczorowski | | | |

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269098

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 5 2 6 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FRANCIS J. LITZ | | | 2a. DATE OF DEATH
MONTH 09 DAY 22 YEAR 85 | | 2b. HOUR
10.02A |
| 3 SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH March DAY 5 YEAR 1909 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
City | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sun Paper-Stereo-typing | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST George MIDDLE Litz LAST Patterson | | | 15 MOTHER'S MAIDEN NAME
FIRST Isabelle MIDDLE Patterson LAST Patterson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
215-03-9203 | | 17 INFORMANT
ADDRESS Mrs. Ella Doris Litz Same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CEREBROVASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF
(c) ENDOCARDITIS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/7 , 19 85 to 9/22 , 19 85 that (I) (we) lost saw the deceased alive on 9/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Christine J. Bell-Lafferman MD | | DEGREE
MD | | 22c. DATE SIGNED
9/22/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHRISTINE J. BELL-LAFFERMAN MD | | 22e. ADDRESS
MERCY HOSPITAL 301 ST PAULS PLACE BALTO. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremate | | 23b. DATE
Sept. 24, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial | |
| 23d. LOCATION
CITY OR TOWN
Catonsville Balto. Md. | | 23e. COUNTY
Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | | |
| 25b. REGISTRAR'S SIGNATURE
Jana Davidson | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| NAME | DATE | AGE | SEX | STATUS | REMARKS |
|--------------|------|-----|-----|--------|--------------|
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |
| W. H. HARRIS | 1903 | 30 | M | W | W. H. HARRIS |

254103

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
Alice Elizabeth Livingston | | | 2a DATE OF DEATH
MONTH DAY YEAR
September 7, 1985 | | 2b HOUR
5:40AM |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 25, 1912 | 6 AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Maryland 13b COUNTY 13c CITY OR TOWN Baltimore | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
3015 Woodhome Ave 21234 |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Thomas Lacey | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Drayer | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b SOCIAL SECURITY NO.
213-28-5717 | | 17 INFORMANT ADDRESS
Mr John G Livingston Same As 13e | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardio Resp Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary Artery Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes Mellitus</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u> | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC)
N/A | | 21f LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 8-2-85 to 8-16-85, that (I) (we) last saw the deceased alive on 8-16-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Anil Sanghrea MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9.9.85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Anil Sanghrea M.D. | | 22e ADDRESS
6919 Harford Rd Baltimore, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/10/85 | | 23c. NAME OF CEMETERY OR CREMATORY
St John's | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
Hydes Baltimore Md | | 25a DATE REC'D. BY REGISTRAR
SEP 9 1985 | | | |
| 24 FUNERAL DIRECTOR
Name ADDRESS
Leonard J Ruck Inc. Baltimore, Maryland | | 25b REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20% COTTON FIBER

WHEATON BRAND



281008

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, item 18 must be marked.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 25270

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>OLY</u> MIDDLE <u>Ruth</u> LAST <u>Lofland</u>
<u>OLY Ruth LOFLAND</u> | | | 2a. DATE OF DEATH
MONTH <u>9</u> DAY <u>28</u> YEAR <u>85</u>
<u>9-28-85</u> | | | 2b. HOUR
<u>7:00</u> P | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Cauc.</u> | | 5. DATE OF BIRTH
MONTH <u>12</u> DAY <u>17</u> YEAR <u>1896</u>
<u>12-17-96</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>88</u> YRS
IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>
IF UNDER 24 HRS HOURS <u>0</u> MIN. <u>0</u> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Alice Manor Nsg. Home</u> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Attendant</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Nursing</u> | |
| 13a. STATE
<u>Md.</u> | | | 13b. COUNTY
<u>Carroll</u> | | 13c. CITY OR TOWN
<u>Union Bridge</u> | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME
FIRST <u>John</u> MIDDLE <u>D.</u> LAST <u>Grabill</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Mary</u> MIDDLE <u>-</u> LAST <u>Rout</u> | | | 16. STREET ADDRESS / ZIP CODE
<u>Whyte St. 21791</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>No</u> | | | 16b. SOCIAL SECURITY NO.
<u>220-54-6681</u> | | 17. INFORMANT
<u>James S. Nott, Randallstown, Md. 21133</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Months</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>Diabetes Mellitus</u> | | | | | | | | |
| 19a. DATE OF OPERATION
_____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR <u> </u> A.M. MONTH <u> </u> DAY <u> </u> YEAR <u> </u>
P.M. <u> </u> 19 <u> </u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET <u> </u> CITY OR TOWN <u> </u> COUNTY <u> </u> STATE <u> </u> | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-19-</u> 19 <u>83</u> , to <u>9-28</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>9-26</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>L. Kemper Owens</u> | | | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>9-30-85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>L. Kemper Owens</u> | | | | 22e. ADDRESS
<u>300 Armory Place (501) Balto, Md. 21201</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>10/2/1985</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Fairmount Cemetery</u> | | 23d. LOCATION
CITY OR TOWN <u>Libertytown</u> COUNTY <u>Maryland</u> | | |
| 24. FUNERAL DIRECTOR
<u>D. R. Hartzler</u> | | | | ADDRESS
<u>Libertytown, Md.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>OCT 4 1985</u> | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | | | | |

26F068

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25271

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|---|---|--|---|--|-------------------------------|---|-------------------------------|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Byron | | | MIDDLE
Logan | | | LAST | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
19 | | | 7b. HOUR
M | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 10 12 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
73 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 8 1985 | | | 7d. HOUR
M
7:35A | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | | 7b. CITIZEN OF WHAT COUNTRY?
US | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2900 Blk. Gwynn Falls Pkwy. | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 11a. STATE
Md. | | | 11b. COUNTY | | | 11c. CITY OR TOWN
Balto. | | | 11d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 11e. STREET ADDRESS
2724 N. Rosedale St. 21216 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Logan | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
139-18-5135 | | | 17. INFORMANT
Ella Logan | | | ADDRESS
2724 N. Rosedale St. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of head (handgun)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | 20. AUTOPSY?
HEAD ONLY
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
self inflicted | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Hanlon Park | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2900 Blk. Gwynn Falls Pkwy, Balto. City, MD. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith, M.D. | | | TITLE (SPECIFY)
Acting Chief MEDICAL EXAMINER | | | | | | | | | | | | | | | DATE SIGNED
9/8/85 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | ADDRESS
111 Penn St. Balto. MD. | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
9/18/85 | | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H, Inc. | | | ADDRESS
West 4300 Wabash Avenue | | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | | | 25b. REGISTRAR'S SIGNATURE
John F. Anderson | | | | | | | | | | |

SECRET

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SECRET

268104

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 25272

| | | | | | | | |
|---|--|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Marie Ann ^a Logue | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 19 85 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 13 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
3456 Hickory Avenue 21211 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Maryland | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Weber | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria (unknown) | | 13e. STREET ADDRESS / ZIP CODE
3456 Hickory Avenue 21211 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
-- | | 17. INFORMANT
ADDRESS
Mrs. Catherine Beall 1353 Weldon Ave. 21211 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration of Food Stomach Contents</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>8 yrs</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2) | | | |
| 21a. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/18</u> to <u>9/19</u> 19 <u>85</u> that (I) (we) last
saw the deceased alive on <u>9/18</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Richard L. Driamond</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard L. Driamond | | 22e. ADDRESS
3547 Chestnut Ave 21211 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
Gina Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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283040

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25273

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------------------|--|---|--|-------------------|--|---|--|---------------------|--|--------------------------------------|--|--------------------------------|--|-------------------------------------|--|---|--|---------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| CHARLES | | M. | | LOHMEYER, JR. | | | | 9 | | 25 | | 19 | | 85 | | | | M | | | | | |
| 1. SEX | | 2. RACE | | 3. DATE OF BIRTH | | 4. AGE (IN YEARS) | | 5. IF UNDER 1 YR. | | 6. IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | | |
| Male | | White | | 12-30-1950 | | 34 YRS. | | | | | | 9 | | 25 | | 19 | | 85 | | 5:45 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Ind. | | U.S.A. | | | | | | | | | | Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | | | 2516 Strathmore Ave. 21214 | | | | Carpenter | | | | Construction | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| Ind. | | | | Baltimore | | | | YES | | | | NO | | | | 2116 Strathmore Ave. 21214 | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | |
| Charles W. Lohmeyer, Jr. | | | | Elizabeth | | | | Yes | | | | 216-50-2520 | | | | Janet D. Lohmeyer 615 Hartwood Lane | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Alcoholism | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | 9-26-85 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | 111 Penn St., Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | | | 9-30-1985 | | | | Bel Air Memorial Garden | | | | Bel Air, Ind. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| John J. Conner | | | | Ind. 21223 | | | | OCT 02 1985 | | | | John J. Conner | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXEMPTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXEMPT THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORMAL RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 11 W. PLESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17

(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER BY TELEPHONE OR IN WRITING. PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR; PAGES 4 AND 5 TO THE CHIEF OF POLICE; PAGES 6 AND 7 TO THE DISTRICT ATTORNEY; PAGES 8 AND 9 TO THE COUNTY CLERK; PAGES 10 AND 11 TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE; DIVISION OF VITAL RECORDS; 401 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|---|--|------------------------------------|--|---|--|------------------|--|---|--|------------------------|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE KNOWN
OF DEATH | | ESTI-
MATED | | MONTH | | DAY | | YEAR | | 26. HOUR | | | | | |
| FRANCISCO | | L. | | | | LOPES | | 9-13-85 | | 19 | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | | 26. HOUR | | | |
| Male | | Black | | 4 30 99 | | 86 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 9-13-85 | | 19 | | 9:35A | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1018 E. 20th Street | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
1018 East 20th Street 21218 | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
1018 East 20th Street 21218 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | | | 16b. SOCIAL SECURITY NO.
020-12-1143A | | | | 17. INFORMANT ADDRESS
Ida L. Lopes 1018 East 20th Street | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE
SIGNED 9-13-85 | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn Street | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
9/16/85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | | | 25b. REGISTRAR'S SIGNATURE
new Davidson-Randall | | | | | | | | | | | | | | | |
| Wm C March F/H Inc. | | | | 1101 E North Avenue | | | | | | | | | | | | | | | | | | | |

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WASHINGTON, D.C.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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1- FOR
STATE
REGISTRAR

REG. NO.

280096

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Josephine Lopez | | | 7a. DATE OF DEATH
MONTH DAY YEAR
9/23/85 | | 7b. HOUR
1925 M |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
3 28 20 | 6. AGE (IN YEARS (LAST BIRTHDAY))
65 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UNK | 7b. CITIZEN OF WHAT COUNTRY?
US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt City MD. | | |
| 10. CITY OR TOWN OF DEATH
Balt | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chair of MD Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Balt 13c. CITY OR TOWN Balt | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216 20 6208 | | 17. INFORMANT
ADDRESS
Beatrice Lopez 2147 Division St. 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
9289 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Intracerebral Hematoma
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertension | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
9/22/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intracerebral Hematoma | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
N/A | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/22 19 85 , to 9/23 19 85 , that (I) (we) last saw the deceased live on 9/22 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Robert B. Burroughs MD | | DEGREE
MD | | 22c. DATE SIGNED
9/23/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |

MEDICAL CERTIFICATION

| | | | |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-27-85 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Maryland |
| 24. FUNERAL DIRECTOR
NAME
Bailey-Douglass Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
OCT 3 1985 | 25b. REGISTRAR'S SIGNATURE
Jake Davidson-Randall |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please note that this certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|---|-----------------------------|
| 1- STATE REGISTRAR 10/22/85 rja | | | | | | | | | | |
| REG. NO. 5 2 5 2 7 6 | | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) Thelma Rose Lovejoy | | | | | 2a DATE OF DEATH
MONTH DAY YEAR
9-26-85 | | | | | 2b HOUR
12:30 P M |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
3 30 00 | | | 6 AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital OF Baltimore | | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a STATE
Md. | | 13b COUNTY | | 13c CITY OR TOWN
Balto. | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
1213 Light St. 21230 | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Logson | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
215-20-6683
212-05-5899 | | 17 INFORMANT
Mr. Alan L. Leslie | | | ADDRESS
523 E. Patapsco Ave. Balto., Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary arrest.
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebro vascular accident.
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Renal failure. | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY
(AT HOME STREET, FACTORY OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-5- 19 85 , to 9-26 19 85 , that (I) (we) last saw the deceased alive on 9-26 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
Matthew | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c DATE SIGNED
9-26-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Matthew | | | | | 22e ADDRESS
Lutheran Hospital 730 Ashburton St. Baltimore | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
10/7/85 | | 23c NAME OF CEMETERY OR CREMATORY
Glen haven Memorial | | | 23d LOCATION
Glen Burnie A.A. County Md. STATE | | | |
| 24 FUNERAL DIRECTOR
NAME
George J. Gonce 4001 Ritchie Hwy. | | | | | ADDRESS
21225 Balto., Md. | | 25a DATE REC'D. BY REGISTRAR
OCT 9 1985 | | 25b REGISTRAR'S SIGNATURE
Lia Davidson-Randall | |

20X COLLECTION LIBER

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) JOHN | | | 2a DATE OF DEATH
MONTH 9 DAY 15 YEAR 85 | | | 2b HOUR 5:54 AM | | |
| 3 SEX MALE | | | 4 RACE CAUCASIAN | | | 5 DATE OF BIRTH
MONTH 05 DAY 01 YEAR 19 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 6 AGE (IN YEARS LAST BIRTHDAY) 66
YRS. MONTHS DAYS HOURS MIN. | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MD 13b COUNTY BALTIMORE | | | 13c CITY OR TOWN BALTIMORE | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST JOHN MIDDLE LECATES LAST LOWREY | | | 15. MOTHER'S MAIDEN NAME
FIRST DELLA MIDDLE SINCLAIR LAST SINCLAIR | | | 13e STREET ADDRESS / ZIP CODE 808 ST. PAUL ST. 21202 | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | 16b SOCIAL SECURITY NO. 216-12-6932A | | | 17 INFORMANT JANE FOBART ADDRESS 4418 BRITTANY DR. E.C. 21043 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GASTROINTESTINAL BLEEDING
DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURE OF GASTROINTESTINAL TRACT
DUE TO, OR AS A CONSEQUENCE OF (c) 24 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 24 hours | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEP 85 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9.14.85 , 19 85 , to 9.15 , 19 85 , that (I) (we) lost saw the deceased alive on 9.14.85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Christine J Bell-Laffer DEGREE MD | | | | | | 22c. DATE SIGNED 9.15.85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINE J BELL-LAFFERMANN | | | | | | 22e. ADDRESS MERCY HOSPITAL BALTIMORE MD | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) CREMATION | | | 23b. DATE 9/16/85 | | | 23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PARK | | 23d. LOCATION
CITY OR TOWN CATONSVILLE COUNTY BALTO STATE MD |
| 24 FUNERAL DIRECTOR
NAME SLACK FUNERAL HOME ADDRESS BOX 268 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1985 REGISTRAR'S SIGNATURE Davidson | | |
| 25b. DATE REC'D. BY REGISTRAR SEP 18 1985 | | | | | | 25c. REGISTRAR'S SIGNATURE Davidson | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2003

2-11-10

268111

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|---|---|--------|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| AMOS | | | H. | LUCAS, | SR. | 9 | 19 | 85 | 4:05 P.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | White | MONTH DAY YEAR
04 07 19 | | 66 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | | Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | John L. Deaton Nursing Home | | | Ret.- Dispatcher | | School | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | |
| 13a. STATE
Maryland | | | | | 13b. CITY OR TOWN
Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
4703 Glenarm Ave. 21206 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST
Henry Adam Lucas | | | | | FIRST MIDDLE LAST
Mary Kohler | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| Yes | | WW II | | Mrs. Ercilia V. Lucas Same as #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>congestive heart failure</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes mellitus</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | STATE |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 21</u> 19 <u>85</u> to <u>Sept 15</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>Sept 15</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Glendon W. Davis</u> | | | | DEGREE | | | 22c. DATE SIGNED
<u>9/19/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Glendon W. Davis</u> | | | | 22e. ADDRESS
<u>611 S. Charles St.</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Entombment | | 9-23-85 | | Moreland Mem. Park | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. | | | | ADDRESS
Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<u>Glendon W. Davis</u> | |
| | | | | | | SEP 23 1985 | | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death, page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, it should be filed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

SECRET

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT R MABRY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9:5:05 | | 2b. HOUR
9:15 A.M. | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 18 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
N. Charles Gen. Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Pattern Maker | | 12b. KIND OF BUSINESS OR INDUSTRY
Airplane | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2525 W. Belvedere Ave. 21215 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert R. Mabry | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Charlotte Crawford | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
233-09-6197 | | 17. INFORMANT ADDRESS
28 Stear Pond Dr. New Freedom, Pa. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) ATHEROSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
PNEUMONIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/12/85 , 19 85 , to 9/5/85 , 19 85 , that (I) (we) lost
saw the deceased alive on 9/5 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
K. DESAI | | | | | | 22e. ADDRESS
North Charles Hospital BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
9/5/85 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

83 49 35 9 9 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

CHIEF

20% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ar, item 1B shows any injury, or other traumatic event, the medical officer or coroner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 7 5 25281 | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
David FRANKLIN Mack | | | | 20. DATE OF DEATH MONTH DAY YEAR
September 13, 1985 | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 4 1909 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 8. AGE UNDER 1 YEAR
MONTHS DAYS
HOURS MIN. | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1027 Cathedral St. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
1027 CHASE ST. 21202 | |
| 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. CITY OR TOWN
BALTIMORE | | 13c. STREET ADDRESS / ZIP CODE
1027 CHASE ST. 21202 | |
| 14. FATHER'S NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CHARLES MACK | | 15. MOTHER'S MAIDEN NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CLEMEE CHRISTOPHER | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
085-10-5066 | | 17. INFORMANT'S ADDRESS
ALBERT HAYES 7525 BROOKEW STAFF COL
21045 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Oat-cell carcinoma of lung</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>1 year</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>1 year</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
(CITY OR TOWN, COUNTY, STATE) | | 22a. I certify that I (this hospital) attended the deceased from <u>9/3/85</u> 19 to <u>9/13/85</u> 19
saw the deceased alive on <u>9/13/85</u> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>W.B. Daniels, Jr. MD</u> DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
W.B. Daniels, Jr. | | 22d. ADDRESS
Union Memorial Aspicce, Balto. 21218 | | 22e. DATE SIGNED
9/13/85 | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
9-18-85 | | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW CEMETERY | |
| 23d. LOCATION
BALTIMORE MARYLAND | | 23e. DATE REC'D. BY REGISTRAR (SIGNATURE) | | 23f. DATE REC'D. BY REGISTRAR (SIGNATURE) | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR (SIGNATURE) | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George Robert Mack III | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 15 1985 | | | 2b. HOUR
8 ⁰⁰ A.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
September 15 1985 | | 6. AGE (IN YEARS LAST BIRTHDAY)
0 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 2 38 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
n/a | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Westminster | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1113 Tall Pines Dr. (21157) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Robert Mack | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dawn Michelle Solloway | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
n/a | | 16b. SOCIAL SECURITY NO.
n/a | | 17. INFORMANT ADDRESS
Theodore Dworkowski 1113 Tall Pines Dr
Westminster Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John Lee</u> | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9-15-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SALVANA M.P. | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
9/17/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE
Brooklyn A.A. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | | | ADDRESS
4001 Ritchie Hwy.
Baltimore Md. 21225 | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will file a report.

BP

October 12, 1952

Mr. Tolson

Mr. E. A. Tamm

Mr. Clegg

Mr. Glavin

Mr. Ladd

Mr. Nichols

Mr. Rosen

Mr. Tracy

Mr. Harbo

Mr. Mohr

Mr. Winterrowd

Mr. Nease

Mr. Gurnea

Mr. Holloman

Mr. Pennington

Mr. Quinn

Mr. Nease

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Nease

Mr. Rosen

Mr. Tamm

Mr. Winterrowd

Mr. Glavin

Mr. Ladd

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

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Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

270020

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 5 2 5 2 8 3

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Rev. Joseph David Mack | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-22-85 | | | 7b. HOUR
11 42 AM | | | | |
| 3 SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 20 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Minister | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md | | | 13b. COUNTY
U.S. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4313 Springdale Ave 21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willie Mack | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(Caldonia) Wyles | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
242-09-2631 | | 17. INFORMANT
Jeanette Mack | | | | ADDRESS
4313 Springdale Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure - acute
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-7, 19 85, to 9-22, 19 85, that (I) (we) last saw the deceased alive on 9-22, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Daniel C. Hagan | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Daniel C. Hagan MD | | | 22e. ADDRESS
Sinai Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
9/27/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md | | |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 4300 Wabash Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 25 1985 | | 25b. REGISTRAR'S SIGNATURE
John W. Anderson | | | |

MEDICAL CERTIFICATION

050050

1958



1958

1958

SEP 20 1958

1- FOR
STATE
REGISTRAR

10-8-85 D.W.

WINFIELD MACKERT

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

WINFIELD

MACKERT.

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

9-29-85

5A.M.

3. SEX

M

4. RACE

W

5. DATE OF BIRTH

MONTH

DAY

YEAR

7

1

99

6. AGE (IN YEARS LAST BIRTHDAY)

86

YRS.

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE
(COUNTRY)

MD USA

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Mt. Vernon Care Center

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Clerical

12b. KIND OF BUSINESS OR

First National Bank

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

3425 Woodstock Ave. 21213

14. FATHER'S NAME

FIRST

MIDDLE

LAST

John W. Mackert, Sr.

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Katherine Glock

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

217-14-1115

17. INFORMANT

ADDRESS

William Mackert, same address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a).

Cardiopulmonary Arrest.

DUE TO, OR AS A CONSEQUENCE OF

(b).

Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c).

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE

AT WORK ☐

NOT WHILE

AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/9, 1985, to 9/29, 1985, that (I) (we) lost
saw the deceased alive on 9/10, 1985, one that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

RUBEN REIDER MD.

22e. ADDRESS

7445 A FURNACE BRANCH RD

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

10/2/85

23c. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery, Balto., Md.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL HOME

NAME

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane, Balto., Md. 21213

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

OCT 1 1985

Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed at once.

MEDICAL CERTIFICATION

259222

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Erwin C. Mahannah | | | | 2a. DATE OF DEATH MONTH DAY YEAR
9 7 85 | | | | 2b. HOUR
10:45pm | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
3 3 09 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS
10 15 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Fulton, N.Y. | | 7b CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
School Teacher Board of Education & Guidance Council - Baltimore City & AA County | | | | | | | |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12b STATE Md. 12c COUNTY Baltimore 12d CITY OR TOWN Catonsville | | | | 13a INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b STREET ADDRESS / ZIP CODE
9 South Beechwood Ave. 21228. | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
William John Mahannah | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret --- Clark | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO.
497-20-1757 | | 17 INFORMANT 9 S. Beechwood Ave. - Catonsville, Md., 21228
Mrs. Elsie O. Mahannah- | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (this hospital) attended the deceased from 9/7/85 to 5/8/85 , that (we) lost 9/7/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | |
| 22a SIGNATURE
[Signature] | | | | DEGREE
[Signature] | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
9/7/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
[Signature] | | | | 22e ADDRESS | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
9/10/85 | | 23c NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery - Baltimore, Maryland | | 23d LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24 FUNERAL DIRECTOR
Sterling Funeral Estate, P. A. | | | | 24b DATE REC'D. BY REGISTRAR
SEP 10 1985 | | 25 REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Handwritten marks and scribbles at the top of the page.



Handwritten marks and scribbles in the middle of the page.

200

Handwritten text at the bottom of the page, including the words "The National" and "Library".

260062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 5 2 5 2 8 0 | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Leonard Frances Mahoney | | | | 2a. DATE OF DEATH
MONTH 9 DAY 10 YEAR 85 | | | | 2b. HOUR 847 P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 1 DAY 9 YEAR 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Policeman-Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto., City | | | |
| 13a. STATE
MD | | 13b. COUNTY
 | | 13c. CITY OR TOWN
Balto. City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3719 Elmora Ave., 21213 | | | |
| 14. FATHER'S NAME
FIRST William MIDDLE Leonard LAST Mahoney | | | | 15. MOTHER'S MAIDEN NAME
FIRST Matilda MIDDLE LAST Cook | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
Yes | | 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
Jacqueline L. Watts | | ADDRESS
4916 Forge Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
pneumonia, COPD, ODS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/7 19 85 to 9/10 19 85 , that (I) (we) last saw the deceased alive on 9/7 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
David S. Dunn | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/10/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID S. DUNN MD | | | | | | 22e. ADDRESS
201 E. UNIVERSITY PKWY | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
9-14-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Maryland | | | | | |
| 24. FUNERAL DIRECTOR
John C. Miller, Inc., 6415 Belair Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

300000

RECEIVED

RECEIVED



NOV 10 1900

RECEIVED



259045

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8-5
CERTIFICATE OF DEATH

REG. NO.

25287

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|---------------------|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HELEN T. MALLICK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 8, 1985 | | 2b. HOUR
1 25 AM | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 20, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Iran | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
214 Northway | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Proprietor | | 12b. KIND OF BUSINESS OR INDUSTRY
Rug Industry | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
214 Northway, 21218 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Soleimen Ackers | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Shaker Casperian | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216 38 2938 | | 17. INFORMANT
ADDRESS
Patricia A. Mallick, Same | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral vascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk.
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 8-10-1981 to 8-8-1985, the (we) lost above (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
E. Hunter Wilson Jr. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
9-9-85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. E. Hunter Wilson, Jr., MD | | | | 22e. ADDRESS
Balto., MD 21201
Medical Srts Bldg., 101 W. Read St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Entombment | | 23b. DATE
9/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Mausoleum | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

• 100% satisfaction guarantee

10812 1994 *Chen*

274093

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 2. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Agnes Mallory</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>September 23, 1985</i> | | 2b. HOUR
<i>3:41 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>10 19 01</i> | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<i>83</i> | | 7. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore</i> MD. | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Maryland General Hospital</i> | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
<i>Maryland</i> | | 12b. COUNTY
<i>Baltimore</i> | | 12c. CITY OR TOWN
<i>Baltimore</i> | |
| 13a. FATHER'S NAME
FIRST MIDDLE LAST
<i>Daniel Curtis</i> | | 13b. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Ella</i> | | 13c. STREET ADDRESS / ZIP CODE
<i>827 Arlington Ave. 21217</i> | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 14b. SOCIAL SECURITY NO.
<i>158-09-1166A</i> | | 14c. INFORMANT ADDRESS
<i>Diann Cash 2402 Pickering Drive Apt. E</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Ischismic Heart Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <i>X</i> (this hospital) attended the deceased from <i>September 19, 19 85</i> to <i>September 23, 19 85</i> , that <i>(X)</i> we last saw the deceased alive on <i>September 23, 19 85</i> , and that in <i>(XX)</i> our opinion death occurred on the date and hour and from the causes stated above. <i>X</i> (we) (did) <i>XXXX</i> view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Jorge E Ferrer M.D.</i> | | 22c. DATE SIGNED
<i>9/24/85</i> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Jorge Ferrer, M.D.</i> | |
| 22e. ADDRESS
<i>c/o Maryland General Hospital</i> | | 22f. DATE RECEIVED BY REGISTRAR
<i>SEP 27 1985</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | | 23b. DATE
<i>9/30/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Anne Arundel Co., Md.</i> | | 23e. FUNERAL DIRECTOR
NAME ADDRESS
<i>Wm C March F/H Inc. 1101 E North Avenue</i> | | | |
| 23f. DATE RECEIVED BY REGISTRAR
<i>SEP 27 1985</i> | | 23g. REGISTRAR'S SIGNATURE | | | |

251033

25% COTTON = 1043

WINTER



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Film G608 item 12a,b,

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 5

2 5 2 8 9

1- FOR 10/4/85 rja
STATE REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
WALTER W. Malloy Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR
9 12 85 | | | 2b. HOUR
2:20 M | | | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
3 12 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
65 YRS | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Correction Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
 jail | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13e. STREET ADDRESS / ZIP CODE
1911 Braddish Ave 21216 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Willis Henry Malloy | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sus Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
214-12-9133 | | 17. INFORMANT ADDRESS
Walter W. Malloy, Jr 419 Scott Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic & cardiogenic shock
DUE TO, OR AS A CONSEQUENCE OF
(b) MI vs Staphylococcal sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) possible endocarditis (acute)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
about 24 hrs
about 2 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a
Hypertension, Diabetes, Chronic Renal Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10 , 19 85 , to 9/12 , 19 85 , that (I) (we) last saw the deceased alive on 9/12 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J. Kinney M.D. | | | | DEGREE | | | | 22c. DATE SIGNED
9/2/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Kinney M.D. | | | | 22e. ADDRESS
Mercy Hospital St. Paul St Balt. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md | | | |
| 24. FUNERAL DIRECTOR NAME
William C. March F/H 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (and in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

BP

285033



254097

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

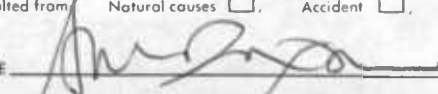

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. CERTAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 FOR
1- STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 25290
REG. NO.

| | | | | | | | | | | | |
|---|-------------------------|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELMORE | | FIRST | | MIDDLE | | LAST
MALONE | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
9 5 19 85 | | 2b. HOUR
M
7:32 A | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
9 30 35 | 6. AGE (IN YEARS)
LAST BIRTHDAY
49 YRS. | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 5 19 85 | | 24 HOUR
A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ala | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
street-1500 blk. School St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Cab Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Transport | | | |
| 13a. STATE
Md | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
626 Payson Street | | 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Roscoe | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
N/A | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
422-38-4550 | | 17. INFORMANT ADDRESS
Dorothy Malone 626 Payson Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wounds of chest and neck (unspecified weapon)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
9-5-5 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot. | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1500 blk. School St., Balto. City MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
9-5-85 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/9/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H Inc 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |

324687

DEPT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MAINTENANCE

RI 1511 NOV 1953 8:00

267047

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

B 5 2 5 2 9 1

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(LAST OR PRINT) Herbert
FIRST H. MIDDLE PIERSON LAST MAPES | | 2a. DATE OF DEATH
MONTH SEPTEMBER DAY 18 YEAR 1985 | | 2b. HOUR
12:50p.m. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH April DAY 3 YEAR 1907 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | 7. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | 8. IF UNDER 1 YEAR
MONTHS 9 DAYS 9 HOURS 9 MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 11. CITY OR TOWN OF DEATH
BALTIMORE | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN RESIDENCE, GIVE ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Advertising Executive | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE New York 13b. COUNTY Rockland 13c. CITY OR TOWN Sloatsburg | | 15. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 16. STREET ADDRESS / ZIP CODE
Route 17 Rockland County | |
| 17. FATHER'S NAME
FIRST Herbert MIDDLE Strong LAST Mapes | | 18. MOTHER'S MAIDEN NAME
FIRST Julia MIDDLE Pierion LAST Pierion | | 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II | |
| 20. SOCIAL SECURITY NO.
061-01-7832 | | 21. INFORMANT
Priscilla G. Mapes, Route 17 Rockland Cty | | 22. ADDRESS
Sloatsburg, New York 10974 | |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uncontrolled metastatic diseases
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of rectal-sigmoid colon
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal failure | | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months
36 months | | 25. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic Renal failure | |
| 26. DATE OF OPERATION
N/A | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 28. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 30. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 32. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 33. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 34. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 35. I certify that (I) (this hospital) attended the deceased from Sept 10 19 85 to Sept 18 19 85 that (I) (we) last saw the deceased alive on Sept 18 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 36. SIGNATURE
Peter Lawrence | | 37. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 38. DATE SIGNED
Sept 18, 1985 | |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER LAI, M.D. | | 40. ADDRESS
Johns Hopkins Hospital Baltimore, MD 21205 | | | |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 42. DATE
9/20/85 | | 43. NAME OF CEMETERY OR CREMATORY
Westview Crematory | |
| 44. FUNERAL DIRECTOR
NAME
Bryan W. Clary, 10 W. Padonia Rd., 21093 | | 45. DATE REC'D. BY REGISTRAR
SEP 20 1985 | | 46. REGISTRAR'S SIGNATURE
John Davidson-Rendell | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

Page 1

Date

Time

City

State

Zip

Phone

Telex

Radio

Mail

Express

Parcel

Postage

Insurance

Signature

Witness

Notary

Agent

Broker

Dealer

Owner

256046

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 2 9 2

| | | | | | | | | | | |
|---|--|--|--|--|---|--|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
THOMAS MARSH Sr. | | | 2a DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 5, 1985 | | | 2b HOUR
11:10PM | | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
5/22/26 | | 6 AGE (IN YEARS LAST BIRTHDAY)
59 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS
HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Alabama | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b KIND OF BUSINESS OR INDUSTRY
South ern Payin CO. | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Florida | | | 13b COUNTY
Hollywood | | 13c CITY OR TOWN
Hollywood | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
5361 Flager St. FL 33020 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Jim Marsh | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie J. Coleman | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. 2 210-26-9089 | | 17 INFORMANT
Annie Marsh 5361 Flager St. Hollywood, FL. 33020 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic AdenoCA - primary unknown</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>3 months</u>
Approximate interval between onset and death: <u>20 min.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>9/5</u> , 19 <u>85</u> , to <u>9/5</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
<u>John P Lavery</u> | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
9-5-85 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN P LAVERY | | | 22e ADDRESS
JOHNS Hopkins Hospital Baltimore MD | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b DATE
9/14/85 | | 23c NAME OF CEMETERY OR CREMATORY
Hollywood Garden | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Hollywood, Florida | | | |
| 24 FUNERAL DIRECTOR
NAME
Chas.A.Rice FSPA 1300 Eutaw Place | | | | | 25a DATE REC'D. BY REGISTRAR
SEP 10 1985 | | 25b REGISTRAR'S SIGNATURE
<u>William Anderson-Randall</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)



Add.info.per F.H. 9/18/85 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

263109

1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Lillie E. Marshall</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-14-85</i> | | | 2b. HOUR <i>5:30 PM</i> | |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>9 26 13</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>71</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New Jersey</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Sinai Hospital</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
<i>Maryland</i> | 13b. COUNTY
<i>21212</i> | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>4504 Eastway 21212</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Unknown Rightmeyer</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Margaret Rubinstein</i> | | <i>Rubinstein</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>218-09-9943</i> | | 17. INFORMANT
<i>Melvin L. Marshall</i> | | ADDRESS
<i>same as 13e</i> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Cardiac Arrest*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*20 min*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Overwhelming Sepsis**2 WKS*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Ruptured Sigmoid Colon**2 WKS*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Respiratory Failure, Myocardial Infarction

19a. DATE OF OPERATION

9/11/85

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Ruptured Sigmoid Colon

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital attended the deceased from *9/11*, 19 *85*, to *9/14*, 19 *85*, that (I) (we) last saw the deceased alive on *9/14*, 19 *85*, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, please do not view the body after death.)

22b. SIGNATURE

J.P. Knud-Hansen, MD

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL STAFF ☒ DIRECTOR ☐ PHYSICIAN ☐

22c. DATE SIGNED

9/14/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

J.P. Knud-Hansen, MD

22e. ADDRESS

*2401 S. Greenspring Ave*23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)*Burial*

23b. DATE

09/17/1985

23c. NAME OF CEMETERY OR CREMATORY

Moreland Mem. Park Green Mount Crematory

23d. LOCATION

CITY OR TOWN COUNTY STATE
Baltimore City, Maryland

24. FUNERAL DIRECTOR

NAME

Walter Brooks Bradley, Inc. Balto., MD 21222

ADDRESS

25a. DATE REC'D. BY REGISTRAR

SEP 16 1985

25b. REGISTRAR'S SIGNATURE

Janie Davidson-Henderson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

275082

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

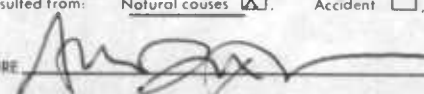
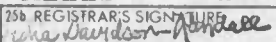
07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 2 9 4
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|------------------|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
HENRY | | MIDDLE
L. | | LAST
MARTIN | | 2a. DATE KNOWN OF DEATH
ESTI- MATED <input checked="" type="checkbox"/> 9 25 19 85 | | 2b. HOUR
M | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 5 1920 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
65 YRS. | | IF UNDER 24 YRS.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
9 25 19 85 | | 7d. HOUR
6:15 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ga. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2726 Edmondson Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Meat Cutter | | 12b. KIND OF BUSINESS OR INDUSTRY
Govt | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2726 Edmondson Ave | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Martin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Viola Dotson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1946-1964 | | 16c. 255 18 1061 | | 17. INFORMANT ADDRESS
Miss Rosalind Martin 601 Madison a | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS CONTRIBUTING <input type="checkbox"/> OR CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
9-26-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
James A. Morton & Sons 1701 Laurens | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

58927

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MA77310

(3)

100% COTTON

249128

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 5 2 5 2 9 5

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|----------------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY M. MARX | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 2 85 | | 2b. HOUR
6:55 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 27 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7405 Bel Clare Road 21222 | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John M. Luskorn | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susan Winkler | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-07-0730 | | 17. INFORMANT
ADDRESS
Rose Turner Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) Hyperglycemic coma
DUE TO, OR AS A CONSEQUENCE OF
(c) UROPERCUSSION | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 min | |
| | | | | | | | | 36 hrs | |
| | | | | | | | | 36 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
None | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
N/A | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A Baltimore City Maryland | | | | | |
| 22a. I certify that (a) this hospital attended the deceased from 9/2 19 85 , to 9/2 19 85 , that (b) I saw the deceased alive on 9/2 19 85 , and that in my (a) opinion death occurred on the date and hour and from the causes stated above, and (b) I did not see the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Stuart Katz MD | | | | DEGREE
MD | | 22c. DATE SIGNED
9/2/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STUART KATZ | | | | 22e. ADDRESS
4940 EASTERN AVE 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/5/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc. | | | | ADDRESS
7922 Wise Avenue Dundalk, Maryland 21222 | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1985 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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260052

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|-------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| MARTENA | | | V. | | | MASSEY | | | 9-10-85 | | | 6 p.m. | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| FEMALE | | | BLACK | | | 7 MONTH DAY YEAR | | | 88 YRS | | | IF UNDER 24 HRS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | | | US | | | | | | Baltimore | | | City MD | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | Union Memorial Hospital | | | DOMESTIC | | | | | | | | |
| 13a STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? | | | 13e STREET ADDRESS / ZIP CODE | | |
| MARYLAND | | | | | | BALTIMORE | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 601 WYANOKE AVE. 21218 | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| WILLIAM | | | MASSEY | | | HATTIE | | | WINN | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| NO | | | | | | WARREN COLEMAN | | | 5352 SINCLAIR LANE | | | 21206 | | |

| | | | |
|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Sepsis</u> | | <u>480</u> | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of Cecum; Intestinal Perforation</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diverticular Dis - GI Bleeding</u> | | <u>1yr</u> | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 8-27-85 | | Carcinoma of Cecum | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NAME OF MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| NA | | HOUR A.M. MONTH DAY YEAR | | NA | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION | | | |
| NA | | NA | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Aug. 22, 1985</u> to <u>Sept. 10, 1985</u> that (we) lost the deceased on <u>Sept. 10, 1985</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE | | | | | | 22c DATE SIGNED | |
| <u>Bannister L. Raines, Jr. M.D.</u> | | | | | | 9-10-85 | |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22f ADDRESS | |
| Bannister L. Raines, Jr. M.D. | | | | | | 5225 York Rd., Balto. Md 21212 | |

| | | | | | | | |
|--|--|----------|--|-----------------------------------|--|---------------------------|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | |
| BURIAL | | 9-16-85 | | Fedar HILL | | BALTIMORE MARYLAND | |
| 24 FUNERAL DIRECTOR | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| E.L. PHILLIPS 1721 N. MONROE ST. | | | | SEP 13 1985 | | <u>James Davidson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30003

CHIEF OF BUREAU

100% COTTON

100% COTTON

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100% COTTON

100% COTTON

270024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGES 5 FOR YOUR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | |
|---|------------------|--|---|--|---|--|--|---|--|---|--|
| ITEM NUMBER 13, PER. C.H. CALL
FOR 10-1-85 D.W.
STATE REGISTRAR Film G608 item 12
1- MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25291 | |
| 1. DECEASED NAME (TYPE OR PRINT) STEPHEN K. MASSEY | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 9 DAY 19 YEAR 85 | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH 4 DAY 23 YEAR 85 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 4 | IF UNDER 1 YR. MONTHS 4 DAYS 4 | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9-19-85 19 | | 2d. HOUR 11:22A | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <input checked="" type="checkbox"/> Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE md. 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTO. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 5410 LEITH ROAD 21239 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Anthony MIDDLE LAST Massey | | | | | 15. MOTHER'S MAIDEN NAME FIRST Felicia MIDDLE White | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Felicia White 5410 Leith Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hydrocephaly
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margareta A. Korell | | | | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 9-20-85 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9-24-85 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | | 23d. LOCATION CITY OR TOWN Anne Arundel COUNTY MD | | | |
| 24. FUNERAL DIRECTOR NAME William C March ADDRESS 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1985 | | | 25b. REGISTRAR'S SIGNATURE Lelia Davidson | | |

07/B4
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(VR A15 ME (5))

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

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| | | | | | | | | | | | |
|--|---------|--|-------------------|---|--|------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| REGINALD MATTHEWS | | | | ESTIMATED MONTH DAY YEAR 9 29 1985 | | | | M 10:45 AM | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| male | black | 7 6 1965 | 20 YRS. | MONTHS DAYS | | HOURS MIN. | | 9 29 1985 | | 10:45 AM | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 10. CITIZEN OF WHAT COUNTRY? | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 12. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md | | U S A | | | | | | Baltimore City MD. | | | |
| 13. CITY OR TOWN OF DEATH | | 14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 15. USUAL OCCUPATION | | 16. TYPE OF WORK | | 17. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | University Hospital (STU) | | | | Laborer | | | | G. B. M. C. | |
| 18a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 18b. STATE | | 18c. COUNTY | | 18d. CITY OR TOWN | | 18e. STREET ADDRESS | |
| | | | | Md | | Baltimore | | Baltimore | | 1811 Thomas Avenue 21216 | |
| 19. FATHER'S NAME | | | | 20. MOTHER'S MAIDEN NAME | | | | 21. INFORMANT | | | |
| Joseph Matthews | | | | Frances Fordham | | | | Frances Matthews 1811 Thomas Avenue | | | |
| 22a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 22b. SOCIAL SECURITY NO. | | | | 22c. ADDRESS | | | |
| No | | | | 215-94-0519 | | | | 1811 Thomas Avenue | | | |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot wound of neck with complications | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (unspecified weapon) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 24a. DATE OF OPERATION | | | | 24b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 24c. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 25a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 25b. TIME OF INJURY | | | | 25c. HOW INJURY OCCURRED | | | |
| | | | | 12:30 AM 9-20-1985 | | | | Subject shot. | | | |
| 26a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 26c. LOCATION | | | |
| | | | | street | | | | 1800 blk. Warwick Ave., Balto. City MD | | | |
| 27a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| 28. ACTUAL SIGNATURE | | | | 29. TITLE (SPECIFY) | | | | 30. DATE SIGNED | | | |
| Ann M. Dixon, M.D. | | | | M.D. Assistant MEDICAL EXAMINER | | | | 9-30-85 | | | |
| 31. EXAMINER'S NAME (TYPE OR PRINT) | | | | 32. ADDRESS | | | | 33. LOCATION | | | |
| | | | | 111 Penn St., Balto., MD 21201 | | | | Baltimore City MD | | | |
| 34a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 34b. DATE | | 34c. NAME OF CEMETERY OR CREMATORY | | 34d. LOCATION | | | |
| Burial | | | | 10/5/85 | | Baltimore Cemetery | | Baltimore City MD | | | |
| 35. FUNERAL DIRECTOR | | | | | | 36a. DATE REC'D. BY REGISTRAR | | 36b. REGISTRAR'S SIGNATURE | | | |
| William C. March F/H Inc West 4300 Wabash Ave | | | | | | OCT 2 1985 | | [Signature] | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR MVA. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

COX COLLEGE LIBS

DAVID

WINTER

2740993

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|------------------|--|--|---|---|---|--|
| 1- FOR 10-2-85 D.W.
STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 25299
REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Ronald S. Matthews | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED XX 9-22 19 85
MONTH DAY YEAR | |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
06-11-48 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
37 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
9-23 19 85
MONTH DAY YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2312 Sidney Avenue | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
STEELWORK |
| 13a. STATE
MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2312 SIDNEY AVENUE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DELORES MATTHEWS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
UNKNOWN | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-46-5467 | | 17. INFORMANT ADDRESS
MILDRED ANDERSON 2312 SIDNEY AVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ethanolism</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED
9-23-85 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
9-28-85 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
NAME
BROWN THOMPSON F.H. | | | | ADDRESS
1913 W. BALTO. ST. | | 25a. DATE REC'D. BY REGISTRAR
SEP 27 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>John Anderson-Andree</i> | | | |

07/B4
25M

BP

DHMH - 17
(VR A15 ME (1))

080175

COLLECTED

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NOV 10 1954

249105

FOR
STATE REGISTRAR Mary C. Matulaitis

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY C. MATULAITIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 2 85 | | | 2b. HOUR
8:35^M | | | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 28 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS
87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALT. GEN HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Button Hole Maker | | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE M.D. 13a. COUNTY A.A. | | | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
111 ALLEN RD. 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Salkavich | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SALLY KURLANSKAS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-01-0589 | | 17. INFORMANT ADDRESS
Marie Prowznik Same as 13e | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiac arrest.**

DUE TO, OR AS A CONSEQUENCE OF

(b) **LEAKING AORTIC ANEURYZM.**

DUE TO, OR AS A CONSEQUENCE OF

(c) **HYPERTENSIVE ATHEROSCLEROTIC DISEASE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

CHRONIC BRONCHITIS ATRIAL FIBRILLATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-1 , 19 85 , to 9-2 , 19 85 , that (I) (we) last saw the deceased alive on 9-2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael Kazak MS | | | | DEGREE | | 22c. DATE SIGNED
9-2-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL KAZAK M.D. | | | | 22e. ADDRESS
3001 South Hanover St. Balt M.D. | | | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
9/5/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Park | | 23d. LOCATION
STREET CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md | |
| 24. FUNERAL DIRECTOR
George J. Gonce | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1985 | | 25b. REGISTRAR'S SIGNATURE
Yana Davidson-Hendall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



ANN V. O. MATHIAS
BALTIMORE, MD.
JAN 10 1901

These are the first three of the
series of photographs taken in
connection with the investigation
of the case of the Baltimore
Baltimore, Md.
JAN 10 1901

These are the first three of the
series of photographs taken in
connection with the investigation
of the case of the Baltimore
Baltimore, Md.
JAN 10 1901

262012

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. BETA IN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25301

| | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH
X MONTH DAY YEAR
9-10-85 19 | | | 2b. HOUR
M | | | | | |
| 3. SEX
Male | | | 4. RACE
Cauc. | | | 5. DATE OF BIRTH
MONTH DAY YEAR
1/19/1910 | | | 6. AGE (IN YEARS)
LAST BIRTHDAY
75 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter-Ret. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Commercial | | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Baltimore City | | | 13c. CITY OR TOWN
Baltimore City | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
5519 Stonington Avenue, 21207 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laula Unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | | 17. INFORMANT
ADDRESS
21207 | | | 17. INFORMANT
ADDRESS
21207 | | | 17. INFORMANT
ADDRESS
21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth | | | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
9-11-85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
9/14/85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Meadoeridge Mem Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge, Howard Co., Md. | | |
| 24. FUNERAL DIRECTOR
NAME
JAMES N. KOTSIS | | | | ADDRESS
FUNDAL HOME, 6411 Windsor Mill Road | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | |

MEDICAL CERTIFICATION

285012

7.

1/17/73 15

U.S.A.

Printer-1st.

2512 Kensington Avenue, 21507

x Baltimore City Baltimore Md

Unknown

Unknown

Label

21507

2512 Kensington Avenue, 21507

21507-21507



21507-21507

21507-21507

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
IDA MAZER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 21 85 | | | 2b. HOUR
6:27 PM | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPTEMBER 28, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANICURIST | | 12b. KIND OF BUSINESS OR INDUSTRY
BEAUTY SALON | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHAIM MILLER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HANNAH UNKNOWN | | 13e. STREET ADDRESS / ZIP CODE
7201 VALLEY COUNTRY CT., APT. B4 21208 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-26-9456 | | 17. INFORMANT ADDRESS
HENRY WOLPERT 21133
8809 STEPHANIE RD., RANDALLSTOWN, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>40 minutes</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) [did not] view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>M. Brock</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | HOUSE STAFF <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCIA V. BROCK | | 22e. ADDRESS
Sinai Hospital of Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
9/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH TFILOH CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|--|---|--|----------------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
HERBERT GARRETT McALLISTER | | | 2a DATE OF DEATH
MONTH DAY YEAR
September 19, 1985 | | 2b HOUR
MIN.
10:45a | |
| 3 SEX
M | | 4 RACE
B | | 5 DATE OF BIRTH
MONTH DAY YEAR
7 28 26 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
59 | | 7a BIRTHPLACE (STATE AND COUNTRY)
BALTIMORE MD. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VA MEDICAL CENTER BALTIMORE | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret | | |
| 12b KIND OF BUSINESS OR INDUSTRY | | 13a STATE
MD | | | | |
| 13b COUNTY
BALTIMORE | | 13c CITY OR TOWN
BALTIMORE | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e STREET ADDRESS / ZIP CODE
633 N. FARMER BLVD 21217 | | 14 FATHER'S NAME
FIRST MIDDLE LAST
Joseph McAllister | | | | |
| 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maude Pierce | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | |
| 16b SOCIAL SECURITY NO
216204321 | | 17 INFORMANT
ADDRESS
Lillian Coates 616 George St apt 4 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) probable pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 14 , 19 85 to Sept. 19 , 19 85 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 19 , 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, mark X.) | | | | | | |
| 22b SIGNATURE
Kerri Hesley MD | | DEGREE
MD | | 22c. DATE SIGNED | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
KERRI HESLEY | | 22e ADDRESS
3900 Loch Raven Blvd. Baltimore MD 21218 | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b DATE
9.24.85 | | 23c NAME OF CEMETERY OR CREMATORY
Baltimore National | | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | 24 FUNERAL DIRECTOR
NAME ADDRESS
William R. Hays 633 N. Farmer St | | | | |
| 25a DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b REGISTRAR'S SIGNATURE
Lillian Coates | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Richard A. McAllister | | | 2a. DATE OF DEATH
MONTH 9 DAY 22 YEAR 85 | | 2b. HOUR
6:10 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH May DAY 10 YEAR 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attorney | | 12b. IND OF BUSINESS OR INDUSTRY
Law |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
705 Chumleigh Rd. 21212 | |
| 14. FATHER'S NAME
FIRST Richard King MIDDLE McAllister LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST Stella Elizabeth MIDDLE Bohannon LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO OR UNKNOWN No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-34-5657 | 17. INFORMANT ADDRESS
Richard A. McAllister, Jr. Balto., Md. 21202 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Prostate Cancer | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/21 , 19 85 , to 9/22 , 19 85 , that (we) last saw the deceased alive on 9/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death. | | | | | |
| 22a. SIGNATURE
Robert Vissing MD | | DEGREE | | 22b. DATE SIGNED
9/22/85 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Vissing, M.D. | | 22d. ADDRESS
Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Sept. 25, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Maria | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Towson, Baltimore Co., Maryland |
| 24. FUNERAL DIRECTOR
NAME Mitchell-Wiedefeld Home, Inc. ADDRESS 6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be contacted at once.

250018



266026

FOR Film G609 item 3
- STATE
REGISTRAR 11/15/85 rjaSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25305

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|--------------------------------|--|-------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| ROBERT | | | | | | McCamery
(MCAMERY) | | X | | 9-14-85 | | | | | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| MALE | | BLACK | | 12 TH 23 22 | | 62 | | MONTHS | | DAYS | | HOURS | | MIN. | | 9-14-85 | | | | 1:20P | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| GEORGIA | | U.S.A. | | | | | | Baltimore City | | | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | 2606 E. Preston Street | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2606 E. PRESTON ST. 21213 | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | | | | | |
| ROBERT Mc CAMERY | | | | | | | | GERTRUDE GORDON GOSS | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| YES | | 253-18-8141 | | DORIS Mc CAMERY | | 2606 E. PRESTON ST. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| | | | | (b) _____ | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | | | (c) _____ | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | chronic alcoholism | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above and in my opinion
death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | M.D. Assistant | | MEDICAL EXAMINER | | DATE
SIGNED | | 9-15-85 | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | Gregory R. Kauffman, M.D. | | ADDRESS | | 111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| BURIAL | | 9-20-85 | | Md. Veteran Cem. | | Crownsville, Md. | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| WM.C. MARCH F/H 1101 E. NORTH AVE. | | SEP 19 1985 | | | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



273075

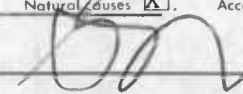
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25306

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | | | | |
|---|--|------------------|--|--|--|---|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Violet Rosalie McCarty | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
9/ 25/ 19 85 | | | 2b. HOUR
M
10:38 A M | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 28 24 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
60 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
524 E. Patapsco Ave. 21225 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Johnson | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Shunelmeyer | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
210-14-5873 | | | | 17. INFORMANT
Baltimore, Maryland 21225
Matthew Tolodziecki 524 E. Patapsco | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | M.D. Assistant | | | | DATE SIGNED 9/25/85 | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | 23b. DATE
9-27-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Vets. Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville A.A. Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McCully Funeral Home 237 E. Patapsco Ave.
Baltimore, Md. 21225 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

SEP 26 1985

253075

20% COTTON BLEND

100% COTTON

100% COTTON

100% COTTON

100% COTTON

100% COTTON

259219

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(LAST, FIRST, MIDDLE)
Millard Wesley McCleary Sr. | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 11 85 | | 2b. HOUR
12 19 PM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 27 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Baltimore Co. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Yard Master | | 12b. KIND OF BUSINESS OR INDUSTRY
Pa. Railroad |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Carroll Westminster | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
525 Mark Drive 21157 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Clarence McCleary | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jennie Painter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
NW IArmy 717-07-7991 | | 17. INFORMANT
ADDRESS
P.O. Box
Butler, Md. 21023 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>prior Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Coronary Artery Disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u>
<u>1977</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-11</u> , 19 <u>85</u> , to <u>9-11</u> , 19 <u>85</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>never</u> , 19 <u>85</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If not, the undersigned view the body after death.) | | | | | |
| 22b. SIGNATURE
<u>Mark F. Frydenborg</u> | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9-11-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK FRYDENBORG MD | | 22e. ADDRESS
2724 N. CHASE ST.
BALTIMORE, MD 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<u>Burial</u> | | 23b. DATE
9-13-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Black Rock Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Butler Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
<u>Thomas D. Fletcher & Son F.</u> | | 25a. DATE RECD. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | |

P 11 32 1947



Center for the Study of
Psychological Problems
1947

2-11-47

1-17-47

275125

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP
DHMH - 17
(VR A15 ME (1))

 1- FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--------------------------------|--|------------------|--|--------------------------------------|--|-------|--|-----------|--|------|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| VINCENT | | | | | | McLeod | | 9 | | 21 | | 19 | | 85 | | 7:06 A.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | | Black | | 12/31/67 | | 18 | | | | | | 9 | | 21 | | 19 | | 85 | | 7:06 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| S.C. | | USA | | | | | | | | | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | University Hosp. (STU) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Md. | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 432 Watty Ct | | | | | | | | | | | | 21201 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| George | | McLeod | | Annie | | McLeod | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| (YES, NO, OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 214-84-6729 | | Annie McLeod | | 432 Watty | | CT. | | | | | | | | | | 21201 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Multiple gunshot wounds (handgun) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | | | (b) | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 4:30xx 9-21- | | 19 85 | | Subject shot. | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | | | |
| street | | | | 1700 blk. Brunt St., Balto. | | | | | | MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | 9-21-85 | | | | | | | | | | | |
| ACTUAL SIGNATURE | | Ann M. Dixon, M.D. | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| Burial | | 9/27/85 | | Cedar Hill Cem | | Brooklyn Md, | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Chas.A.Rice FSPA | | 1300 Eutaw Place | | | | SEP 30 1985 | | John Davidson-Randall | | | | | | | | | | | | | |

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REBEL MOTION PICTURE

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MILK RAY



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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 25309

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JOSEPH LAWRENCE MCCONVILLE, SR. | | 2a. DATE OF DEATH MONTH DAY YEAR
9/21/85 | | 2b. HOUR
1:35 AM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
11 17 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attendant | | 12b. KIND OF BUSINESS OR INDUSTRY
Race Track |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | 13b. COUNTY
Howard | 13c. CITY OR TOWN
Ellicott City | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH BERNARD MCCONVILLE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY LORETTA COATES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
217-01-9246 | | 17. INFORMANT
Helen Joanne Fleck 4412 Dorado Dr. 21043 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

END TERMINAL RESPIRATORY FAILURE stage 5

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

SEVERE CHRONIC COPD PULMONARY - YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c)

SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE - YEARS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/20 1985, to 9/21 1985, that (I) (we) last saw the deceased alive on 9/20 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

MARCONIO F AUGUSTINE MD 1540 W. Balto St Balto MD 21223

| | | | |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9/24/85 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Maryland |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | 25b. REGISTRAR'S SIGNATURE
Jina Davidson |

MEDICAL CERTIFICATION

9/21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 3 1 0
CERTIFICATE OF DEATH

| | | | | | |
|---|-------------------------|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM MCCORD | | MONTH DAY YEAR
9 28 85 | | 142 am | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
12/22/10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Schenley Co. | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edgar McCord | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Freeland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 215-07-9501 | | 17. INFORMANT ADDRESS
Helen McCord, 3507 Dudley Ave. 21213 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF:
(b) SQUAMOUS CELL CARCINOMA OF LUNG
DUE TO, OR AS A CONSEQUENCE OF:
(c) TUBERCULOSIS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: TUBERCULOSIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 SEPT 19 85 to 20 SEPT 19 85 , that (I) (we) last saw the deceased alive on 20 SEPT 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE
GA Hopper MD | | DEGREE
MD | | 22c. DATE SIGNED
9/20/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GAYLE A. Hopper, MD | | 22e. ADDRESS
UMH, BALTIMORE, Md. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/1/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | 23e. DATE REC'D. BY REGISTRAR
OCT 1 1985 | | 23f. REGISTRAR'S SIGNATURE
John Davidson Randall | |

MEDICAL CERTIFICATION

1

9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

General director, page 2
72 hours after death.

9

RECEIVED 10/10/30

10/10/30

RECEIVED 10/10/30

10/10/30

X

RECEIVED 10/10/30

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RECEIVED 10/10/30

256018

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 5 2 5 3 1 1

FOR
1 - STATE
REGISTRAR

| | | | | | | |
|--|--|---|--|--|---------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
BLAIR G MC CRACKEN Jr. | | | 2a DATE OF DEATH
MONTH DAY YEAR
September 6, 1985 | | 2b HOUR
8:43a M | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
7 11 25 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
60 | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VA MEDICAL CENTER BALTIMORE MD | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sheet Metal Worker | | |
| 12b KIND OF BUSINESS OR INDUSTRY
Guard | | 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Maryland 13b COUNTY A.A. 13c CITY OR TOWN Baltimore 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS / ZIP CODE 604 Old Riverside Road 21225 | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Blair G. McCracken Sr | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Ward | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
WW II 190 16 2484 | | 17 INFORMANT
ADDRESS
Michael B. McCracken 228 Edgevale Rd Balto Md 21225 | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest 2° hypotensionAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF
(b) **Enrhes GI bleed**DUE TO, OR AS A CONSEQUENCE OF
(c) **Cirrhosis**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that XX (this hospital) attended the deceased from August 24, 1985 to September 6, 1985 that X (we) last saw the deceased alive on September 6, 1985 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X we) (d) XXXXXX view the body after death. | | | | | | | |
| 22b SIGNATURE
S. Marshall mp | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/6/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. Marshall mp | | 22e ADDRESS
3900 Loch Raven Blvd. Baltimore MD 21218 | | | | | |

| | | | | | | | |
|---|--|----------------------------|--|---|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
9/9/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto Md | |
| 24 FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto Md | | | | 25a DATE REC'D. BY REGISTRAR
SEP 10 1985 | | 25b REGISTRAR'S SIGNATURE
John A. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the funeral home's permit. Then please make out the necessary papers. Page 4 and 5 should be filled in by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.)

WIKI
11/11/12

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State of Virginia

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 5 3 1 2

REG. NO.

| | | | | | | | | | | | |
|--|-------------------------|---|--------|---|---|---|---|--|-------------------|--|-------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
<i>Elouise</i> | MIDDLE | LAST
<i>McCray</i> | 2a. DATE OF DEATH | | MONTH
<i>9</i> | DAY
<i>5</i> | YEAR
<i>85</i> | 7b. HOUR
<i>7:25</i> | MIN.
<i>AM</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>Black</i> | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>S.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balt</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>UMH</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Unemployed</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>N/A</i> | | | | |
| 13a. STATE
<i>MD</i> | | | | 13b. COUNTY
<i>Bate</i> | | 13c. CITY OR TOWN
<i>Balt</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>625 N. Bentalou St. 21216</i> | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST
<i>Arthur</i> | | | | MIDDLE
<i>Rufus</i> | | LAST
<i>(Flores)</i> | | FIRST
<i>Lizzie</i> | | MIDDLE
<i>(Dickie)</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | | | 16b. SOCIAL SECURITY NO.
<i>214-26-6773</i> | | 17. INFORMANT
ADDRESS
<i>Linda Byrd 625 N. Bentalou St.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Respiratory</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Pneumonia</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>9/2/85</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
<i>Severe Rheumatoid Arthritis, Anemia, Hypertension, heart</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/4</i> 19 <i>85</i> to <i>9/5</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>1:am 9/5</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Karen T. Jordan MD</i> | | | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>9/5/85</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Karen T. Jordan MD</i> | | | | | | 22e. ADDRESS
<i>UMH Dept Psychiatry</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | | 23b. DATE
<i>9/10/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arbutus Memorial Park</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Arbutus MD</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>William C. March F/H Inc. 4300 Wabash Avenue</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>SEP 9 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Galia Davidson-Randall</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 777-1234.

224031



1100 1008

CHIEFMAN

248116

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 1 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH H. MCCUBBIN | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 2 85 | | 2b. HOUR
5:25 A.M. | |
| 3 SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1-16-1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE WORK FOR MOST OF WORKING LIFE)
Water Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. City |

| | | | | | |
|---|---|--|---------------------------------------|---|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Md. | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS, ZIP CODE
6410 Walther Ave. Apt. B1 -21206 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph H. McCubbin | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary J. Keenan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-20-8941 | 17. INFORMANT
ADDRESS
Mrs. Mary J. McCubbin 6410 Walther Ave. Apt. B1 Balto. Md. -21206 | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) ESOPHAGEAL CANCER.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 HOURS. |
|---|--|--|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1 , 19 85 , to 9/2 , 19 85 , that (I) (we) last saw the deceased alive on 9/2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
P. P. KITCHIN | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/2/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. P. KITCHIN | | 22e. ADDRESS
UNIONMEMORIAL HOSPITAL | |

| | | | |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
9-5-85 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
John C. Miller Inc. -6415 Belair Road-21206 | | 25a. DATE REC'D. BY REGISTRAR
SEP 3 1985 | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall |

BP
DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

()

1-10-1933

1-10-1933

1-10-1933

1-10-1933

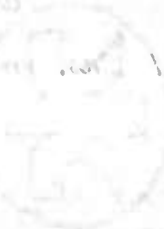
1-10-1933

1-10-1933

1-10-1933

1-10-1933

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1-10-1933

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1-10-1933

1-10-1933

254066

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the card from this page and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic external cause, a medical examiner must be notified at once.

BP

DHMM - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 3 1 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|--|--|--|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES J. McDONALD | | | 2a. DATE OF DEATH
MONTH 9 DAY 7 YEAR 85 | | | 2b. HOUR
8:15 AM | | | | | | |
| 3 SEX
MALE | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH 7 DAY 4 YEAR 20 | | 6 AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS | | 8 IF UNDER 24 HRS
HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
CITY 21211 MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WYMAN PARK HEALTH SYSTEM | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chief Warrant Officer-U.S. Army | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21222 1928 Barry Rd. Balto Md. | | | |
| 14 FATHER'S NAME
FIRST James MIDDLE J. LAST McDonald | | | 15 MOTHER'S MAIDEN NAME
FIRST Marie MIDDLE LAST Murphy | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
WWII-Korea Viet Nam
209-09-7694 | | 17 INFORMANT
Marie J. McDonald | | | ADDRESS
Same as 13e | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMATOSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) Adenocarcinoma - Lung
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
18 months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
8-29-85 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
SHASTROSTOMY - Gastrostomy | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-16 , 19 85 , to 9-7 , 19 85 , that (I) (we) lost
saw the deceased alive on 9-7 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
A. Y. AKRAWI | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
9-7-85 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANIS Y. AKRAWI | | | 22e. ADDRESS
WYMAN PARK HEALTH SYSTEM | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9/11/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Virginia | | | | |
| 24 FUNERAL DIRECTOR
NAME Duda-Ruck, Inc. ADDRESS
7922 Wise Avenue Dundalk, Maryland 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

MEDICAL CERTIFICATION

221066

APR 28 5 49 PM '66
TO: SAC, NEW YORK
FROM: SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]



254040

Film G607 item 5

1- FOR 9/16/85 jps
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 1 5

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(Last, first, middle)
<i>Robert T. B. McElroy (Clark)</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9-6-85</i> | | 2b. HOUR
<i>22:12 PM</i> | |
| 3. SEX
<i>male</i> | 4. RACE
<i>Caucasian</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>8-28-85</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS HOURS MIN.
<i>11</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Mercy Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF PRECEDING YEAR)
<i>N/A</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>N/A</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
<i>Md.</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Robert T. McElroy Sr.</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Karen L. Clark</i> | | 16. STREET ADDRESS / ZIP CODE
<i>1293 William St. 71230</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>1</i> | | 17. INFORMANT
ADDRESS
<i>Karen L. McElroy 71230 St. 1293 William</i> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) *Cardiorespiratory failure*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Severe lung disease*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Prematurity*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Intracranial hemorrhage, multiple air leaks

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Bonita J. Makdadi</i> | | 22c. DATE SIGNED
<i>9-6-85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Bonita J. Makdadi</i> | | 22e. ADDRESS | |

| | | | |
|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(IF BY OTHER THAN FUNERAL HOME, GIVE NAME AND ADDRESS)
<i>Burial</i> | 23b. DATE
<i>9/9/85</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Glen Haven Cem.</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>1501 E. Fort Cap Rd. Baltimore</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Charles R. Stevens</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>SEP 9 1985</i> | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

527000



254056

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 3 1 6
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MACKIE E. Mc FALL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 07, 1985 | | 2b. HOUR
4:45 A.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCTOBER 12, 1907 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
TEXAS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
117 TREMONT ROAD 21229 | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAMUEL ALFORD | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DORA COOLEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
465-16-5714 | | 17. INFORMANT
ADDRESS
CARLIS W. Mc FALL 117 TREMONT ROAD 21229 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Immediate

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|------------------------|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|---|---|

| | | |
|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|--|--|--|

| | | |
|---|--|---|
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
|---|--|---|

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on 9/6 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (If (we) did not view the body after death.)

| | | |
|--|---------------------|-----------------------------------|
| 22b. SIGNATURE
<i>Paul E. Gormley</i> | DEGREE
<i>MD</i> | 22c. DATE SIGNED
<i>9/7/85</i> |
|--|---------------------|-----------------------------------|

| | |
|--|---|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. PAUL E. GORMLEY / Dr. WATERFIELD | 22e. ADDRESS
ST. AGNES HOSPITAL |
|--|---|

| | | | |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/10/85 | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE 21229 | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | 25b. REGISTRAR'S SIGNATURE
<i>Golia Davidson-Rendon</i> |

524026



281002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 5 2 5 3 1 7

CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | MONTH DAY YEAR | | HOUR MIN. | |
| Elizabeth McGee | | 9/30/85 | | 4:10 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| F | B | MONTH DAY YEAR | | 76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Kendonia | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | | Univ Md Hosp | | Cty | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CASE, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | Univ Md Hosp | | Not Employed | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Baltimore | | Md | | Md | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | |
| Vincent | | Marie | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 217-09-7688 | | Susie Waters | | 818 Fremont Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ble brainstem stroke</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| None | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | P.M. NA 19 | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> , 19 <u>85</u> , to <u>9/30</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/30</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| N. Hershkovitz | | | | 9/30/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| N. Hershkovitz | | Univ Md Hospital | | 22 Green St, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 10/7/85 | | Westview Memorial Pk | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| William C. March F/H Inc | | OCT 4 1985 | | Julia Davidson-Henderson | |
| NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| West 4300 Wabash Ave | | OCT 4 1985 | | Julia Davidson-Henderson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

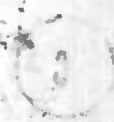
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Bulge

20% COTTON

WILLY R. H. II



267089

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 3 1 8
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(LAST, FIRST, MIDDLE)
Daniel JAMES McKernan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 17, 1985 | | 2b. HOUR
11:50am | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 8 1941 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital, Baltimore | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Data Processing | | 12b. KIND OF BUSINESS OR INDUSTRY
Social Security Admin. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
3214 Lawnview Ave. 21213 | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel P. McKernan | | | | | |
| 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret T. Suter | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | | |
| 16b. SOCIAL SECURITY NO.
219-38-8000 | | | 17. INFORMANT
ADDRESS
Daniel McKernan (father) same address | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable pulmonary hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Probable Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) years | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
years | |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Anemia, ventricular arrhythmia**

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION
Sept 17, 1985 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Sept 17, 1985 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 17, 1985 to Sept 17, 1985 , that (I) (we) last saw the deceased alive on Sept 17, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Joseph Kinn | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | TH. DATE SIGNED
9/17/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HYUN JOSEPH Kinn | | 22e. ADDRESS
301 St Paul Place, Baltimore MD | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/21/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL HOME
Schrimmek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 20 1985 | | 25b. REGISTRAR'S SIGNATURE
G. A. Smith | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be brought in at once.

BP

20 COTTON FIBER

MADE IN U.S.A.



263105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Arthur E. McKewin | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09 11 85 | | 2b. HOUR
7:05P _M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 6, 1900 | 6. AGE (IN YEARS LAST BIRTHDAY)
85
YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | 12b. KIND OF BUSINESS OR INDUSTRY
Gas Station | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1001 Argonne Dr. 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Harrison McKewin | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora May Hedley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-22-9617 | 17. INFORMANT
ADDRESS
Mrs. Helen E. McKewin 1001 Argonne Dr. 21218 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>ACUTE PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ACUTE PULMONARY EDEMA, 2° RECENT MYOCARDIAL INFARCTION</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1/2 wk</u>
<u>5 days</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>CORONARY ARTERY DISEASE, S1P ME X 4, CHRONIC CHF</u> | | | | | |
| 19a. DATE OF OPERATION
— | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. — 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
— | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
— | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> , 19 <u>85</u> , to <u>9/11</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Eleanore M. Ebert</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>9/11/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ELEANORE M. EBERT</u> | | 22e. ADDRESS
<u>Union Memorial Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-14-85 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home 6500 York Road 21212 | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>J. A. Davidson-Randall</u> | |

BP

259179

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|-------------------------------------|--|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) VINCENT J. McMAHON | | | 2a. DATE OF DEATH
9-11-85 | | 2b. HOUR
1:40 pm | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
FEB 15, 1909 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZENSHIP
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | |
| 7c. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JENKINS MEMORIAL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. CITY OR TOWN
CATONSVILLE | | 13c. STREET ADDRESS / ZIP CODE
205 EAST MEDWICK GARTH 21228 | | |
| 14. FATHER'S NAME
FIRST PHILLIP MIDDLE J. LAST McMAHON | | 15. MOTHER'S MAIDEN NAME
FIRST ANNIE MIDDLE MURPHY LAST MURPHY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
215-10-5707 | | 17. INFORMANT
MARY JANE CRISP ADDRESS
12405 SHELTER LANE 20715 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gangrene of Foot.
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis with
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) dissecting aortic aneurysm | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-14-85 , 19, to 9-11-85 , 19, that (I) (we) last saw the deceased alive on 9-11-85 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
George Angov DEGREE | | | | 22c. DATE SIGNED
9-11-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE ANGOV | | | | 22e. ADDRESS
3350 Wilkens Ave - Balt | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
09-14-85 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK MAUSOLEUM | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE | | 23e. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | ADDRESS
4107 WILKENS AVENUE | | 25a. REGISTRAR'S SIGNATURE
John Davidson-Randall | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed with the medical examiner.

BP

031023

STANDARD & S. CO. ST. LOUIS, MO.

28-1-31



For your information
the following is a list of
the items on the list

1. 100 lbs. of flour

2. 100 lbs. of sugar



263053

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Helen M. McManus | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 10 85 | | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 12 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5421 Channing Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Lady-Retired | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5421 Channing Rd. #21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen ? | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
212-16-8041A | | 17. INFORMANT
5421 Channing Rd. - Balto., Md.
Helen Drummond #21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of Colon with Metastases</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Anemia</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2-3 days
1 1/2 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-14-76, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on 2-3-85, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Harry S. Gimbel M.D. | | | | DEGREE | | | | 22c. DATE SIGNED
9. 11. 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HARRY S. GIMBEL | | | | 22e. ADDRESS
5226 BALTO. NAT. PIKE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-13-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Pk. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab | | | | 25a. REC'D BY REGISTRAR
5151 Balto. Nat'l. Pike
#21229 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



261002

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 3 2 2

| | | | | | | | | |
|---|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) AMANDA Leigh MCMULLEN | | | 2a. DATE OF DEATH MONTH DAY YEAR
SEPTEMBER 4, 1985 | | 2b. HOUR
09:15AM | | | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 11, 1980 | | 6. AGE (IN YEARS LAST BIRTHDAY)
5 YRS
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Delaware | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Child | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. STATE
Delaware | | | | 13b. COUNTY
Kent | | 13c. CITY OR TOWN
Hartly | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Marion McMullen | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pamela Masten | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT ADDRESS
Pamela M. McMullen RD 1 Hartly, Del. 19953 | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrhythmias
DUE TO, OR AS A CONSEQUENCE OF (b) Low flow state, metabolic aberrations
DUE TO, OR AS A CONSEQUENCE OF (c) S/P Modified Fontan Procedure
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours | |
| 19a. DATE OF OPERATION
9-3-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
HLV MS USD, PA Band, S/P C.O.A | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
J. Shumway | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9-4-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SHUMWAY / REITZ | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL DEPARTMENT OF CARDIAC SURGERY | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Sharon Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dover Kent Delaware | | |
| 24. FUNERAL DIRECTOR
NAME
Wells A. Faries | | 29 S. Main St.
Smyrna, Del. 19977 | | 25. DATE REC'D. BY REGISTRAR
SEP 9 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

5 191 16 70 A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner, it should be detached for use as the burial/transit permit. Then please remove (detach) pages 1 and 2 and completely filled in by the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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e/le

267103

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25323

| | | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Marvin McQueen Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 18, 1985 | | 2b. HOUR
M | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 22 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)
3505 Menlo Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3505 Menlo Dr. 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
? McQUEEN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CATHERINE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
240-07-7150A | | 17. INFORMANT
ADDRESS
MARVIN McQUEEN JR. 3505 MENLO DR. 21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Chronic exertional desultory ulcer of right heel</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 19, 1985</u> , to <u>Sept. 18, 1985</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 4, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jerome H. Ginsberg</u> | | | DEGREE
M. D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
9-19-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jerome H. Ginsberg, M. D. | | | 22e. ADDRESS
8630 Liberty Plaza Mall
Randallstown, Md. 21133 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
9/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
CAROLINA GARDENS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RELEIGH NORTH CAROLINA | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 20 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>J. Davidson-Randall</u> | | |

MEDICAL CERTIFICATION

77

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

30103

20% COTTON FIBER

MADE IN U.S.A.



260105

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 2 4

1- FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|--|--|---|-----------------------------------|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Alice F McRAE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/9/85 | | 2b. HOUR
14.45 M. | |
| 3 SEX
F | 4 RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
1 30 40 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
45 YRS. | 7. UNDER 1 YEAR
MONTHS DAYS
45 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
VA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | |
| 10. CITY OR TOWN OF DEATH
BATT. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
U. of MD Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OR SPECIFY NATURE OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MD BATT. BATT. | | | 14. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 15. STREET ADDRESS / ZIP CODE
139 N. S. MORE ST 21217 | |
| 14. DECEASED'S NAME
FIRST MIDDLE LAST
CARRIE - GREEN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FAILLERS - Hodge | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215349209 | | 17. INFORMANT
NAME ADDRESS
Infant Reg. Record | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRAIN DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Subarachnoid - Intracerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) this hospital attended the deceased from 9/8/85 to 9/9/85 that (i) (we) last saw the deceased alive on 9/9/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ii) (we) (did) not visit the body after death. | | | |
| 22b. SIGNATURE
Machado | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
9/9/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Machado | | 22e. ADDRESS
22 S. Green St BATT. | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/13/85 | 23c. NAME OF CEMETERY OR CREMATORY
CROWNSVILLE VET. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
LEROY O. DYETT 4600 LIB. HIGHTS. AVE. | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | 25b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, show any injury, or other traumatic cause of death.



259173

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page always be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies and 2 should be filed within 72 hours after death. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or other funeral service. If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lloyd ANTHONY MCSHANE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 9, 1985 | | 2b. HOUR
MIN
11:35^A | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 16 15 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 8. IF UNDER 24 HRS
HOURS MIN
0 0 | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RIGGER | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
BETHLEHEM STEEL | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | |
| 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1111 Park Avenue, 21201 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN McSHANE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LILLIE MAE GRAY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 212-09-9294 | | 17. INFORMANT
ADDRESS
MARY LEE, 2833 EDGEComb CIRCLE, NORTH | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (X) (this hospital) attended the deceased from August 9 , 19 85 , to September 9 , 19 85 , the XX (we) lost saw the deceased alive on September 9 , 19 85 , and that in xy (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (XXX) view the body after death. | | | | |
| 22b. SIGNATURE
Christopher D. Hogan M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
Sept 9, 1985 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Christopher D. Hogan, M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9-13-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL CEMETERY | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | 24. FUNERAL DIRECTOR & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PARKWAY, BALTO., MD. 21216 | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
SEP 13 1985 | | | | |

MEDICAL CERTIFICATION

BP

37103



256015

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NORMA G. MEADE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 5, 1985 | | 2b. HOUR
3:20 am | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 30 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
MD | | 13b. COUNTY
HOWARD | | 13c. CITY OR TOWN
ELLICOTT CITY | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES HENRY MEADE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY GERTRUDE ECKENRODE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
220/54/5512 | |
| 17. INFORMANT
ADDRESS
WILLIAM SCHAEFFER 18 RIDGE RD. 21228 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Urinary Tract Infection; Organic Brain Syndrome; Congestive Heart Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 17, 19 85 to September 5, 19 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 5, 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thomas H. Ganey, MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas H Ganey, M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. JOHNS CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ELLICOTT CITY HOWARD MD | |
| 24. FUNERAL DIRECTOR
NAME
SLACK FUNERAL HOME | | ADDRESS
BOX 268 ELLICOTT CITY, MD 21043 | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | | 25b. REGISTRAR'S SIGNATURE
Wardson-Rendell | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 about any injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with this certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been used by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The license remains the property of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



259095

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|------|---|-------------------|--|---|-----------------------------------|--|----------------|--------------------------------------|---------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Robert | | | | Meadows | 9 | | 7 | 85 | | 9:00 AM | |
| 3. SEX | Male | 4. RACE | | Black | 5. DATE OF BIRTH | | MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| | | | | | 7 | | 4 | 21 | | 64 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | V.A. | 7b. CITIZEN OF WHAT COUNTRY? | | USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| | | | | | | | | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | South Baltimore Gen. Hosp. | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | ZIP CODE | | |
| Md | | Baltimore | Baltimore | | | | 3025 Larue Square | | 21225 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Charles | | OIA | | | | 225-14-6067 | | MOSSIE MEADOWS | | S/A WIFE | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Chronic Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Congestive Heart Failure

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN COUNTY STATE | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19, 1985, to 9/7, 1985, that (I) (we) lost
saw the deceased alive on 9/7, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| [Signature] | | | | 9/7/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Accevedo | | 3001 S. Hanover St. Balt. Md. | | | | | |

| | | | | | | | |
|---|--|-------------------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | 9/10/85 | | CEDAR HILL | | ARUNDEL Co. Md | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| BROWN THOMPSON | | AUG 31 1985 | | Julia Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the permit from page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

220002



RECEIVED
MAY 10 1962

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259168

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALL INFORMATION ON THIS FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT DEATH PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

Items 10-22a 10/30/85 mth F#608 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1-
FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------|------------------|---|----------------|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Curtis Lee Megginson Jr. | | | 8-30 1985 | | | 4:48 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 2d. HOUR | |
| Male | Black | 12 9 58 | 26 YRS. | | | 8-30 1985 | 4:48 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | | U.S.A. | | | Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Baltimore | | | Johns Hopkins Hospital | | | Recreation Dept. | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. STREET ADDRESS | | |
| Maryland | | | Baltimore | | | 2901 Lakebrook Circle 21227 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | |
| Curtis Lee Megginson Sr. | | | Catherine Wilson | | | no | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| 219-70-3843 | | | Catherine Page | | | 2901 Lakebrook Circle | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Sudden Cardiac Arrest</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | |
| (b) <u></u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) <u></u> | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> <u>Heart</u> <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| <u>Dennis F. Smyth M.D.</u> | | | Assistant | | | 8-31-85 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | 23b. REGISTRAR'S SIGNATURE | | |
| Dennis F. Smyth, M.D. | | | 111 Penn St., Balto., Md. | | | 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | | 9-6-85 | | Eastview Cemetery | | Baltimore Maryland | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| William J. Spicer F.H. 1639 N. Broadway | | | | | SEP 13 1985 | | <u>Pandora</u> | |

BP 315

252168



x

263093

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|---|--|--------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HUGO - MELE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09/11/85 | | 2b. HOUR
12 ¹⁵ M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 10, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF BUSINESS, OCCUPATION, OR SERVICE)
Sheet Metal Instructor | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael Mele | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine Magrone | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | |
| 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT
ADDRESS
Mr. Thomas W. Mele 1600 W. 41 st. Street | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Dehydration

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 days

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Chronic myelogenous leukemia

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

transitional cell CA, COPD, Pleural effusion

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION
none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
none | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from Sept 10, 1985, to Sept 11, 1985, that (2) we last saw the deceased alive on Sept 11, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE
Mertine R. Jermamy | | | | DEGREE MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/11/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MERTINE R. JERMAMY | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Sept. 14, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

Abstract

• **Time**

•

9-114

254049

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25330
REG. NO. | |
|--|--|-------------------------|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ALTON LEE MELSON | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19
9-2-85 | | 2b. HOUR
AM PM
12:00 | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC 4, 1960 | | 6. AGE (IN YEARS LAST BIRTHDAY)
24 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 19
9-2-85 | | 7d. HOUR
AM PM
12:00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Northern Pkwy. & Exit 32 off ramp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY
MACHINE SHOP | | |
| 13a. STATE
MARYLAND | | | 13b. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8101 RIDGETOWN DR. APT A | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HERBERT V. MELSON SR. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AGNES I. MURRAY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
221-44-7087 | | 17. INFORMANT
ADDRESS
HERBERT MELSON CHARLOTTESVILLE, VA | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
11:17PM 9-2-85
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver of auto/fixed object impact | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
hgw. | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Northern Pkwy. & JFK west off: Balto., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korel</i> | | | | TITLE (SPECIFY)
M.D. Asistant | | | | MEDICAL EXAMINER
111 Penn Street | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korel, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
9/5/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. GEORGE'S CEMETERY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CLARKSVILLE SUSSEX DELAWARE | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Frankford</i> | | | | ADDRESS
MELSON FUNERAL SERV FRANKFORD, DELAWARE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

321043

8



91113 101103 1863

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper and return it to the funeral director. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

268103

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Marrin L. Memmert | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/18/85 | | | 2b. HOUR
8 P.M. | | | |
| 3 SEX
male | | 4 RACE
caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
5/3/15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
B. City. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital 21215 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frederick Memmert | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen Miller | | | 13e. STREET ADDRESS / ZIP CODE
3806 Hickory Ave. 21211 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT ADDRESS
Eileen Memmert 3806 Hickory Ave. 21211 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) oat-cell ca of the lung
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immediate
6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/4, 19 85, to 9/18, 19 85, that (I) (we) lost saw the deceased alive on 9/18, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Richmond P. Allan MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/18/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richmond P. Allan | | | 22e. ADDRESS
Sinai Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

SEP 23 1985

INDEX



1

2/2/8



259121

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

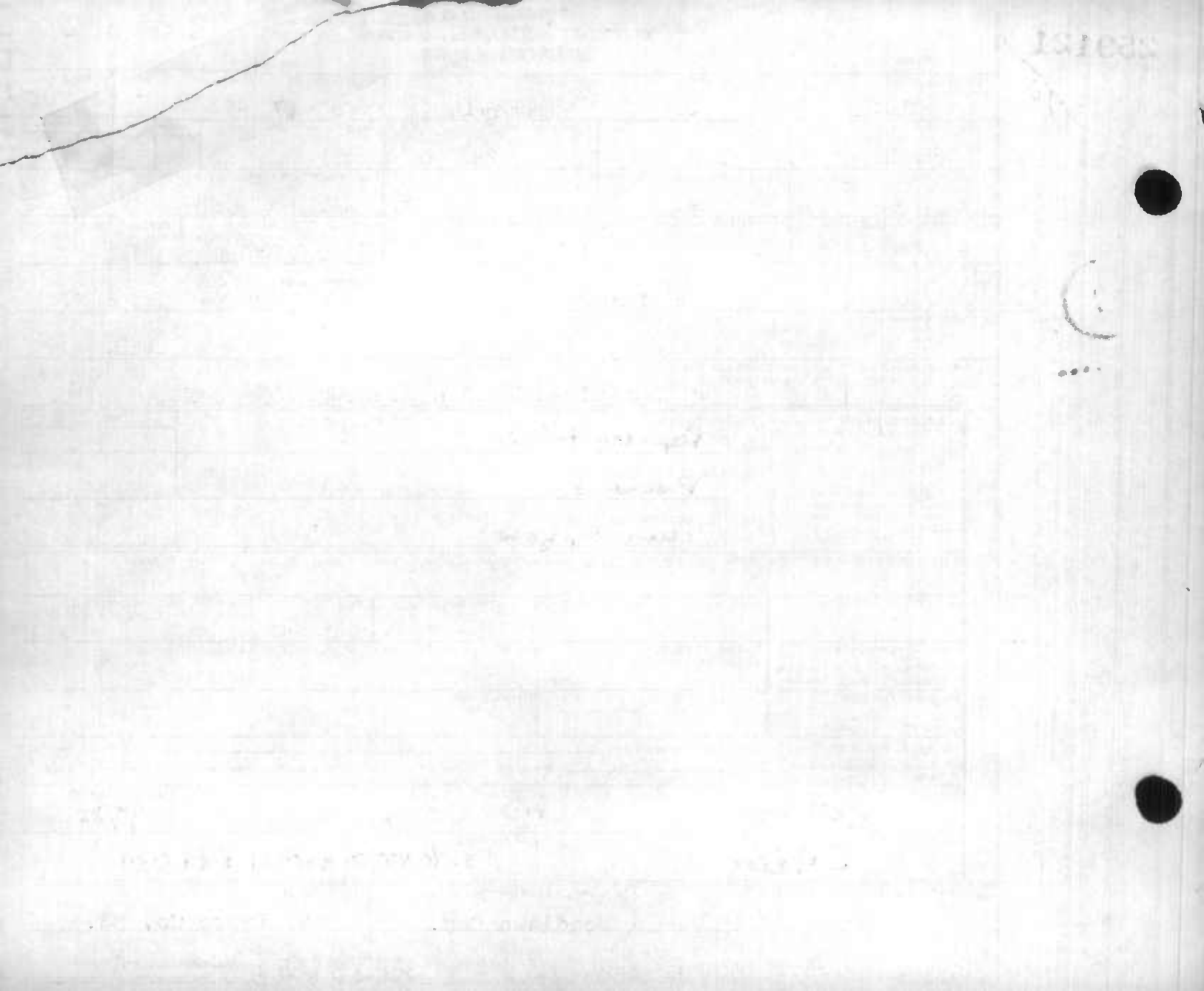
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 5 2 5 3 3 2 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MILDRED J. MENDENHALL | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 07 85 | | 2b. HOUR
M | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 29 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
815 N. MONROE STREET | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TOLL OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
AT&T | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
815 N. MONROE STREET, 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PAUL JONES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDNA QUEEN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | |
| 16b. SOCIAL SECURITY NO.
213-20-5979 | | 17. INFORMANT
ADDRESS
GWENDOLYN M. BROWN, 2400 EDMONDSON AVENUE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic emphysema</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert A. Berg</u> | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
9/5/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R A Berg | | 22e. ADDRESS
S. DE 400, 711 WYCK ST. Bkpt 21211 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
9-12-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
NUTTER & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PARKWAY, BALTO., MD. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John W. Anderson</u> | | | | | |

BP _____

DHMH - 16 50M 4/83

(VRA 15, 4)



254073

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 5 3 3 3
2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 9 7 19 85
2b. HOUR 12:08
2c. DATE PRONOUNCED DEAD 9 7 19 85
2d. HOUR a M

1- FOR
STATE
REGISTRAR

| | | | | |
|--|------------------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Russell Patrick Menta | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9 7 19 85 | | 2b. HOUR 12:08 |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR March 5 1967 | 6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS. | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | 10. CITY OR TOWN OF DEATH
Baltimore | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
Education |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Timonium | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13d. STREET ADDRESS
4 Overgate Court, 21093 | | 14. FATHER'S NAME FIRST MIDDLE LAST
Russell C. Menta | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Josephine P. Martini | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | |
| 16b. SOCIAL SECURITY NO.
216-94-8559 | | 17. INFORMANT ADDRESS
Russell C. Menta, 4 Overgate Court, 21093 | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries with complications
8151
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21093 |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|--|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:25xx 8 28 19 85 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Passenger in auto/fixed object impact |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
Girdwood & Treherne Rds, Baltimore, MD. |

22a. I certify that I took charge of the remains described above, held in Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *Thomas D. Smith* TITLE (SPECIFY) Acting Chief MEDICAL EXAMINER DATE SIGNED 9/7/85
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto. MD.

| | | | |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
9/10/85 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE
Timonium Balto. Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Bryan W. Clary, 10 W. Padonia Rd., 21093 | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> |

DIVISION OF VITAL RECORDS, 301 W. BAYVIEW ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF "CAUSE OF DEATH". GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALSO, WITH FORM PW 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. BAYVIEW STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

070525

513



252146

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|--|---|---------------------------|--|
| DECEASED NAME
(TYPE OR PRINT) DARLENE R. MERRITT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-1-85 | | 2b. HOUR
345 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 18 54 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
31 YRS. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 10. CITY OR TOWN OF DEATH
Baltimore | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Donald Carville Merritt | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Shirley May Ruffino | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Donald Merritt 1201 Hillshire Rd. 22 | | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) increasing respiratory distress
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Right lung pneumonia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-1-85 , to 9-2-85 , that (I) (we) last saw the deceased alive on 9-2-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Stanley D. Drake, M.D. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
9-2-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stanley D. Drake, M.D. | | | | 22e. ADDRESS
4940 Eastern Ave. | |

| | | | | | |
|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/5/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Connelly Funeral Home 300 Mace Ave. 21221 | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

28

252142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 3 5

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) PATRICIA A. MESSARIS | | | 2a. DATE OF DEATH
MONTH 9 DAY 3 YEAR 85 | | | 2b. HOUR
M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 12 DAY 28 YEAR 40 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF HUNGARY HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 7205 German Hill Road 21222 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST Lawrence MIDDLE Buehner LAST Elizabeth | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Elizabeth MIDDLE Sewell LAST Sewell | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-36-2655 | | 17. INFORMANT
Roy E. Messaris | | | ADDRESS
Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) GASTRIC CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 months |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/22 , 19 85 to 9/3 , 19 85 that (I) (we) lost
saw the deceased alive on 9/3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Christine J Bell-Lafferma M.D. DEGREE MD | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/3/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHRISTINE J BELL-LAFFERMAN M.D. | | | | | | 22e. ADDRESS
301, ST. PAUL'S PLACE, BALTO. MD 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9/6/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Of Jesus | | 23d. LOCATION
CITY OR TOWN Dundalk COUNTY Baltimore STATE Maryland | | |
| 24. FUNERAL DIRECTOR
NAME Duda-Ruck, INC. ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 5 1985 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

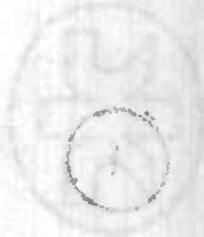
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper and page 2 should be filed with 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, (medical examination) to be made and signed by a physician.

CLASS

2029



266074

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---|---|--------|--|---|--|--|---|
| DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| GERTRUDE | | | | MICHALSKI | SEPTEMBER 14, 1985 | | 11:30AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 72 HRS |
| FEMALE | CAUC. | MONTH DAY YEAR
11 13 04 | | 80 YRS | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MD | USA | | | BALTIMORE City MD | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | CHURCH HOSPITAL | | | HOME MAKER | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? |
| MD | | | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| MARTIN | | | | UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | |
| NO | | 48-07-30074 | | MARIE Smith 911 S. Potomac St. 21224 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure CONGESTIVE HEART
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACVD ARTERIOSCLEROTIC CARDIOVASCULAR
DUE TO, OR AS A CONSEQUENCE OF DISEASE
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| | | AUGUST 30 85 | | SEPTEMBER 14 85 | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-30-85 to 9-14-85, that (I/we) last saw the deceased alive on 9-14-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death.) | | | | | | | | |
| 22b. SIGNATURE
Thomas C. Detweiler, MD | | | | DEGREE | | | 22c. DATE SIGNED
9-14-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas C. Detweiler, MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | |
| THOMAS C. DETWEILER, MD. CHURCH HOSPITAL CORPORATION | | | | 100 N. BROADWAY, BALTIMORE, MD. 21231 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| BURIAL | | 9/18/85 | | ST Stanislaus Cem | | BALTO MD. | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Kaczorowski Funeral Home 5525 Fleet St. | | | | SEP 19 1985 | | [Signature] | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



269074

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25337

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|---|--|-------------------------|--|--|----------------|---------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2b. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2d. HOUR | | | | | | | | | | | |
| MELVIN JOSEPH MIELKE, JR. | | | | | | 9-19-85 | | | 19 | | | 11:07 AM | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | | | | | |
| MALE | | WHITE | | JULY 09 1950 | | 35 YRS. | | | | | | 9-19-85 | | 19 | | | | | | | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | | | University Hospital STU | | | | Unemployed | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | | | 13b. CITY OR TOWN | | | | | | | | | | | |
| Maryland | | | | | | | | | | | | Baltimore | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| Melvin J. Mielke, Sr. | | | | | | | | | | | | Martha May Triggers | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | | |
| NO | | | | | | | | | | | | 216-54-6744 | | | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | | | ADDRESS | | | | | | | | | | | |
| Diana L. Osgood | | | | | | | | | | | | 116 S. Prospect Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Stabwound of posterior thorax</u> | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> : | | | | | | | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | | | 7:45AM 9-19-85 | | | | subject stabbed | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, OFFICE, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | | | |
| | | | | home | | | | #12 Virginia Ave. CITY OR TOWN Glen Burnie, Maryland | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | M.D. Assistant | | | | 111 Penn Street | | | | 9-20-85 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | | | 9/23/85 | | | | Meadowridge Mem. Pk. | | | | Elkridge | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| NAME | | | | ADDRESS | | | | 21229 | | | | SEP 24 1985 | | | | | | | | | | | |
| Hubbard Funeral Home, Inc. | | | | 4107 Wilkens Ave. | | | | | | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

170032



Handwritten signature or text, possibly "J. A. ..."

Handwritten text at the bottom, possibly "July 28 1938"

259217

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mrs. P. Patricia Milani | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 10 1985 | | | 2b. HOUR
1:06 AM | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 30 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(GIVE FULL NAME AND STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR "OF WORKING LIFE")
Structural Aid | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. County | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2019 Kennicott Road 21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mr. Walter D. Hyle | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mrs. Elizabeth M. Nevin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | 16b. SOCIAL SECURITY NO.
212-26-2688 | | 17. INFORMATION ADDRESS
2019 Kennicott Road Baltimore Maryland 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular failure
DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Myeloma | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/2 , 19 85 , to 9/10 , 19 85 , that (I) (we) lost
saw the deceased alive on 9/10 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) not view the body after death. | | | | | | | | | | |
| 27b. SIGNATURE
Richard J. G. B... | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 27c. DATE SIGNED
9/14/85 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard J. G. B... | | | 27e. ADDRESS
Sinai Hospital, Baltimore, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | 23b. DATE
9-14-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, Maryland 21133 | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use at the burial/cremation. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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273004

166 Per F.H. 10-485 Km

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 3 9

1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|-------------------------------------|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RUTH C. MILBURN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-16-85 | | 2b. HOUR
4:15
A M |
| 3. SEX
4 | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
2 12 9 / 92 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS
IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk - | 12b. KIND OF BUSINESS OR INDUSTRY
Penna. RR |
| 13a. STATE
Florida | | | 13b. COUNTY
- | 13c. CITY OR TOWN
- | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Thomas Burnham | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Christina G. Manger | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-22-6884 | | 17. INFORMANT
ADDRESS
Walter T. Burnham 8929 D. Waltham Woods Rd. 21234 | |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF
(b) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
(c) unknown. | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Heart Failure - | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/16, 19 85, to 9/16, 19 85, that (I) (we) last saw the deceased alive on 9/16, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
BUI T DUONG | | DEGREE
M.D. | | 22c. DATE SIGNED
9-16-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BUI T DUONG | | 22e. ADDRESS
LUTHERAN HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-19-85 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Lassahn Funeral Home | | 7401 BELAIR RD.
BALTO. MD. 21236 | | 25a. DATE REC'D. BY REGISTRAR
20 85 | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove checkboxes on pages 1 and 2 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified in case.

POETS

1. ~~_____~~

260036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
AUDREY M MILLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 7 85 | | 2b. HOUR
3:36a.m. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
July 24, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Taylor, Pa. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven V/A Medical Cen. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Reg. Nurse | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE
N.J. | | | 13b. COUNTY
Ocean | 13c. CITY OR TOWN
Pt. Pleasant | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Not - Available | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth N/A | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes-Army | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1951-53 | | 17. INFORMANT (son)
ADDRESS
Peter Servon Carlisle, Pa. 17013 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UNCALHEMATION
DUE TO, OR AS A CONSEQUENCE OF (b) HYPOXIC ENCEPHALOMALACIA
DUE TO, OR AS A CONSEQUENCE OF (c) HEMANGIOBLASTOMA
Approximate interval between onset and death: 2 WEEKS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WEEKS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a | | | | | |
| 19a. DATE OF OPERATION
8/23/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
POSTERIOR FOSSA BIAX | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 11b, PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 9, 1985, to SEPTEMBER 7, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPTEMBER 7, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE
THOMAS N WERB | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/10/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS N WERB | | 22e. ADDRESS
LOCH RAVEN VA HOSP | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9-13-85 | 23c. NAME OF CEMETERY OR CREMATORY
Franklin Mem. Pk. | | 23d. LOCATION
CITY OR TOWN STATE
Middlesex Co. N.J. |
| 24. FUNERAL DIRECTOR
NAME
E. Barnes
Fleming Funeral Service- Benson, Md. | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be submitted to the State Dept. of Health and Mental Hygiene.



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REG. NO.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|--|--------------|--|---|--|--|--|---|--|--|--|--|---------------------|--|---------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Reinold | | | MIDDLE
E. | | | LAST
Miller | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9-29 19 85 | | | 2b. HOUR
M 10:45 | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
July 17 1894 | | 6. AGE (IN YEARS)
94 | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD
10-1 19 85 | | | 2d. HOUR
M 10:45 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1440 Boyle Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY
— | | | | | |
| 13a. CITY OR TOWN
Md. | | | | 13b. COUNTY
— | | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
1440 Boyle St. 71230 | | | | | |
| 14a. FATHER'S NAME
John Miller | | | | 14b. MOTHER'S MAIDEN NAME
Frances Rice | | | | 15. MOTHER'S MAIDEN NAME
FIRST LAST | | | | 16. SOCIAL SECURITY NO.
318-10-0994 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
Yes Army | | | | 16b. SOCIAL SECURITY NO.
318-10-0994 | | | | 17. INFORMANT
James J. 435 Meadow Rd. 71206 | | | | 17. ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Cachexia | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
10-1-85 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | |
| 23a. INITIAL, CREMATION, REMOVAL
(BY)
Cremation | | | | 23b. DATE
10/2/85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Christiansburg Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY
615 Rustin Ave. Md. 71228 | | | | | |
| 24. FUNERAL DIRECTOR
Charles L. Stevens | | | | ADDRESS
501 E. 7th Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John H. ... | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. IN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

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DHMH - 17
(VR A15 ME (5))

POINTS



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MADE IN

100% COTTON

THE MANUFACTURER'S MARK
REGISTERED TRADE MARK
MADE IN

275018

Film G608 item 1

FOR 10/24/85 rja
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|------------------------|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Ronda RHONDA L MILLER | | | 2a DATE OF DEATH
MONTH DAY YEAR
09 16 1985 | | 2b HOUR
4:55PM
M | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 10, 1978 | | 6 AGE (IN YEARS LAST BIRTHDAY)
6
YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Frederick | | 13c. CITY OR TOWN
Frederick | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
336 Madison Street 21701 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Kenneth W. Miller | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Robin J. Stoner | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17 INFORMANT
Mrs. Robin J. Miller
336 Madison St., Frederick, Md. 21701 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Neuroblastoma</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intracerebral metastatic Neuroblastoma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>24 hrs</u>
<u>2 yrs</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Intracerebral metastatic Neuroblastoma</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT ORR <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22 I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 19 <u>85</u> , to <u>9/16</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/16</u> , 19 <u>85</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Joseph M Wiley</u> | | | | DEGREE
<u>M.D.</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>9/16/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Joseph M Wiley M.D.</u> | | | | 22e ADDRESS
<u>601 N Wolfe St Balto. Md.</u> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>9-20-85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mount Olivet Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Frederick, Frederick, Md.</u> | | | |
| 24 FUNERAL DIRECTOR
NAME
<u>Smith, Keeney & Basford Funeral Home</u> | | | | 24a. DATE REC'D. BY REGISTRAR
<u>SEP 24 1985</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Julia...</u> | | | |
| 106 East Church St., Frederick, Md. 21701 | | | | | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be advised and a report filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner, it should be detached for use on the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

275012

4 21 20 215 2



UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

Approved: _____

254068

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 3 4 5
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|------------------|---|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Walter Miller | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
9-3 1985 | | | | 2b. HOUR
M
9:40 p.m. | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 18 28 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
57 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9-3 1985 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1020 McDonough Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | | 13b. CITY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
302 E. LANVALE APT #1 | |
| 14. FATHER'S NAME
WESLEY MILLER | | | | | | 15. MOTHER'S MAIDEN NAME
UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
BEULAH RUCKER 1020 McDONALD ST. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Diabetes Mellitus | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED
9-4-85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
9/10/85 | | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW CEMETERY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 30 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGINS OF THIS PAGE. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS PAGE. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

SEP 9 1985

SEP 9 1985

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

521088

60% COTTON FIBER



MADE IN U.S.A.

254138

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|--|---|---------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| JESSE MILLIGAN | | SEPTEMBER 6 1985 | | 11:35 ³ m. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS (LAST BIRTHDAY)) | 7. IF UNDER 1 YEAR | |
| MALE | Black | Sept 9 1916 | 98 | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | | | |
| Balto. MD. | Baltimore City | Balto. | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Chesest Home Hosp. | Truck driver | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Balto. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 127 Druid Hill Ave. 2121 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| Jessie | Mary | YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute anterior myocardial infarction | | | |
| 217-05-0478 | Pauline Milligan | CEREBROVASCULAR ACCIDENT | | | |
| | | (b) WITH LEFT HEMIPLEGIA | | | |
| | | (c) DUE TO, OR AS A CONSEQUENCE OF BILATERAL PNEUMONIA | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 - 20 19 85, to 9-6-88 19 85, that (I) (we) lost the deceased alive on 9 - 6 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (add) did not view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATES SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| | MD | 9/6/85 | | IMPAGLIATELLI, WALKER | |
| 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | |
| 100 NORTH BROADWAY | | Burial | | | |
| BALTIMORE, MARYLAND 21231 | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | SEPT. 12, 88 | | KING MEM. PARK | |
| | | 23d. LOCATION | | 24. FUNERAL DIRECTOR | |
| | | BALTO. COUNTY MD. | | NAME - THOMPSON 1913 W. BALTO. ST. | |
| | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | SEP 9 1985 | | John Davidson-Randall | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

324158



277153

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Fannie E. Mills</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9/29/85</i> | | 2b. HOUR
<i>10⁵⁵ AM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>5 16 1916</i> | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<i>69</i> YRS | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Ga.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Provident Hosp</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE
<i>md</i> | | 13b. COUNTY | |
| 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS, / ZIP CODE
<i>4116 Kathland Ave 21207</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Austin Farley</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Fannie Farley</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>254-20-8513</i> | | 17. INFORMANT
ADDRESS
<i>Frank Mills 4116 Kathland Ave</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio Pulmonary Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Chronic Renal Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<i>CHF, PVD</i> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <i>9/29</i> 19 <i>85</i> , to <i>9/29</i> 19 <i>85</i> , that (I) (we) last
saw the deceased alive on <i>9/29</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Eleanor Y. Hixon, MD</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>9/29/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Eleanor Y. Hixon MD</i> | | 22e. ADDRESS
<i>3100 Towanda Ave Baltimore 21215</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>10/4/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Garden Of Eternal Hope</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Westminister Annapolis Md</i> | | 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>William C. March F/H Inc West 4300 Wabash Ave</i> | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<i>Oct 2 1985</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or registrar, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

021775



280071

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 5 3 4 8

1- FOR
STATE REGISTRAR Unknown #85-75

| | | | | | | | | | | | |
|---|---------|--|-------------------|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| Vandoria Mills | | | | 9/ 28/ 85 | | | | 5:58 A | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | |
| F | B | 9 18 65 | 20 YRS. | | | | | 9/ 28/ 85 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Baltimore | | U.S.A. | | | | Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Johns Hopkins Hospital | | | | | | | | | |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. CITY OR TOWN | | | | 13c. STREET ADDRESS | | | |
| Maryland | | | | Baltimore | | | | 1119 Mcaleer Ct. 21202 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Garrison Brown | | | | Castile Mills | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| no | | | | 212-42-1689 | | | | Garrison N Brown 329 E. Lanvale St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple Stab Wounds | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | 4:30am 9/ 28/ 85 | | | | subject stabbed | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | street | | | | 900 Blk. N. Ensor St., Balto. City, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Margarita A. Korell, M.D. | | | | M.D. Assistant | | | | 9/28/85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| BURIAL | | | | 10-4-85 | | | | Baltimore | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| W.C. March F/H Co. | | | | OCT 2 1985 | | | | Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-100. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

280071

DAVID WILKINSON

REPT NOTION 1972

252112

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

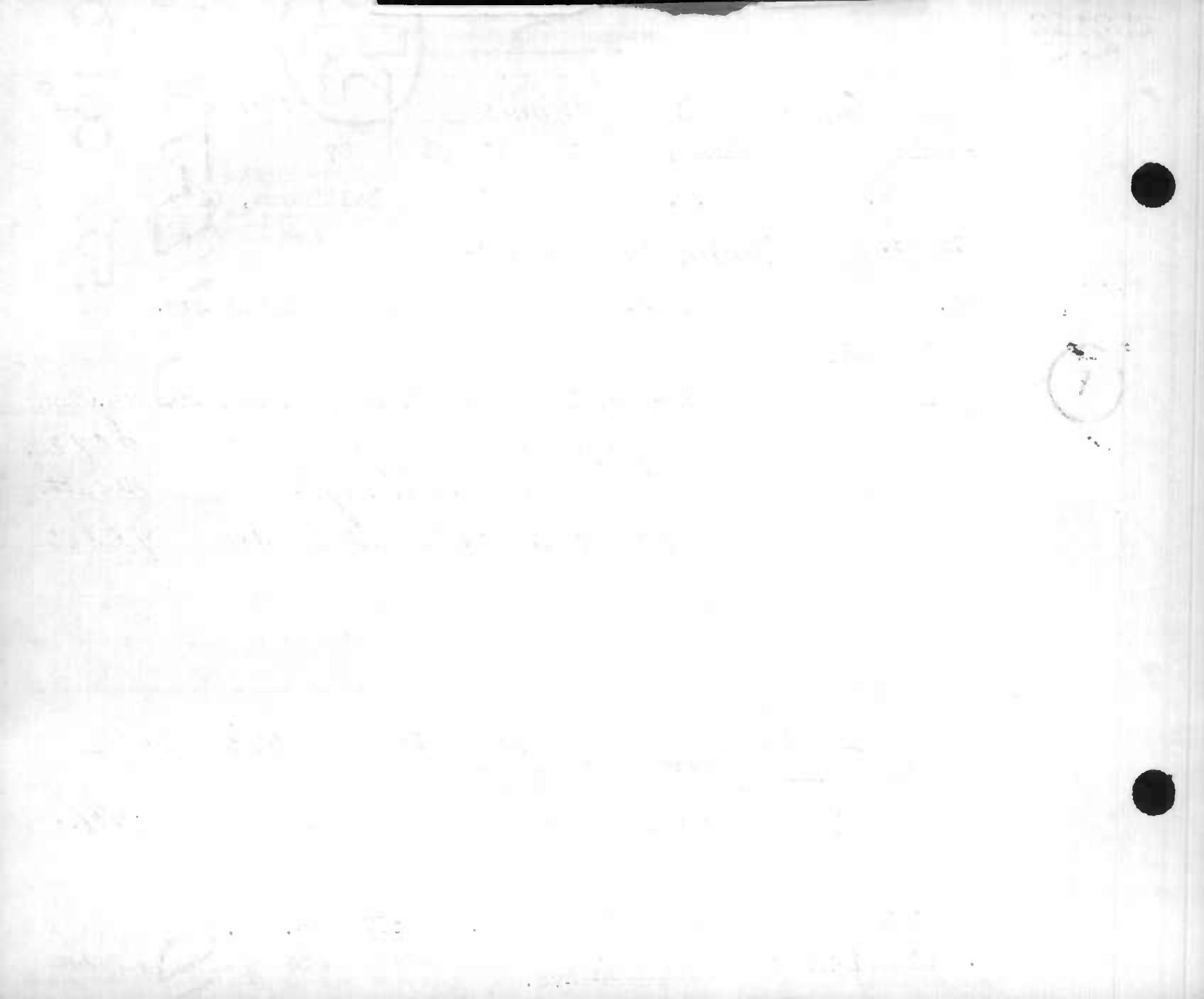
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral home must be notified above.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Sallie C Minnis</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9-4-85</i> | | 7b. HOUR
<i>6 A M</i> | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Black,</i> | | 5. DATE OF BIRTH
<i>10th 10 98</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>87</i> | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore, City</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Deaton Med Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<i>Md.</i> | | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>3222 Belmont Ave. 21216</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Eddie Cosby</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | | 16b. SOCIAL SECURITY NO.
<i>213-01-74150</i> | | 17. INFORMANT
ADDRESS
<i>Edwin Minnis 3222 Belmont Ave. Son</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Decubiti - mal Fele</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Par kin son's Dis ease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>days</i>
<i>months</i>
<i>years</i> | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <i>11/17</i> , 19 <i>84</i> , to <i>9/4</i> , 19 <i>85</i> , that (a) (we) last saw the deceased alive on <i>9/4</i> , 19 <i>85</i> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>J.R. Gladen, MD</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>9/4/85</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>9/7/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arbutus Mem. Park</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Balto. Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>C. Wainwright</i> | | | | | ADDRESS
<i>2700 Edmondson Ave.</i> | | 25. DATE REC'D. BY REGISTRAR
<i>SEP 06 1985</i> | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |

BP



254137

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

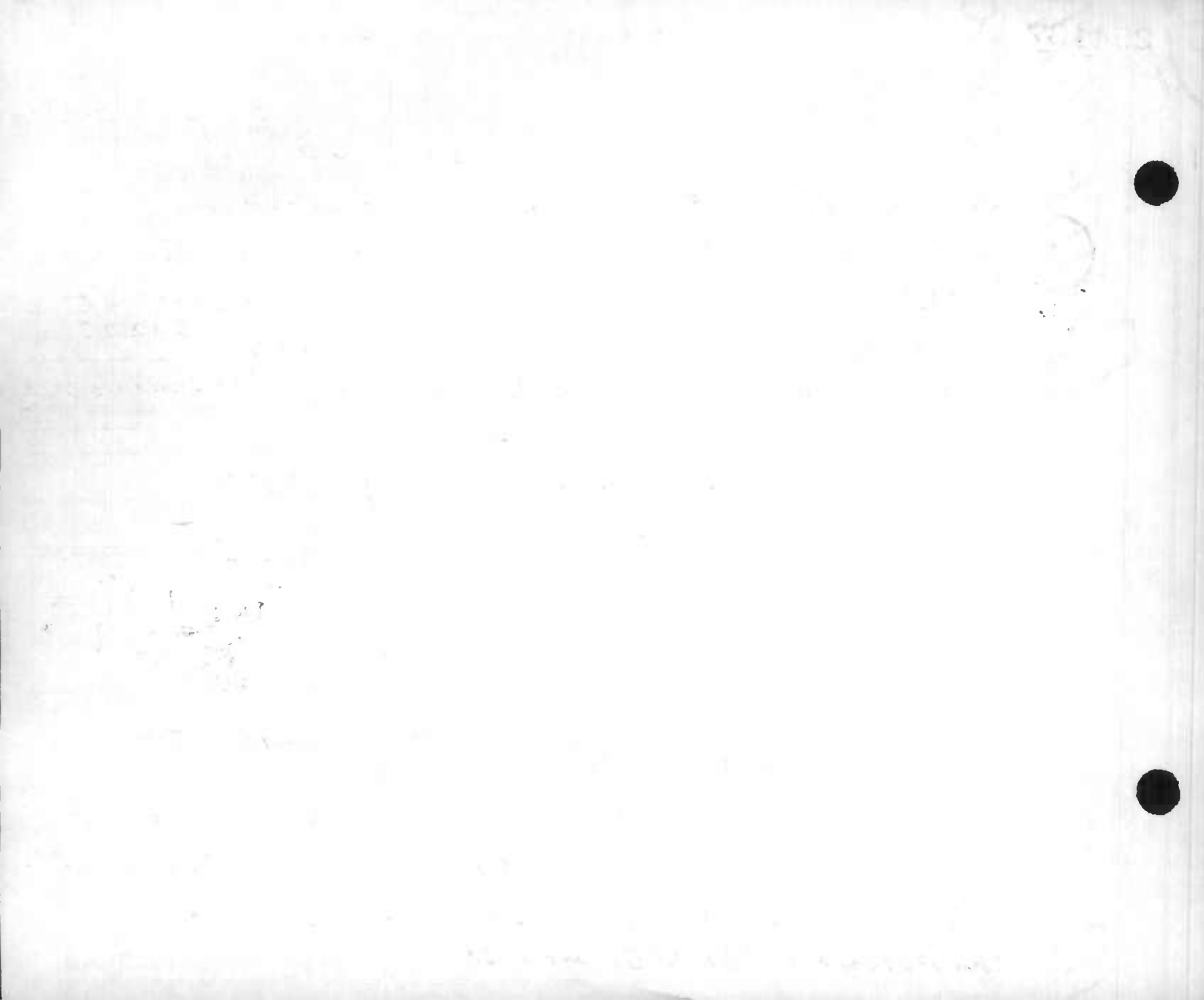
| | | | | | |
|---|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| Cecil L. Mitchell | | 9 6 85 | | 4:20 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| M | B | MONTH DAY YEAR | 60 YRS | BALTIMORE CITY MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| NEWPORT NEWS | USA | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | John L. Deaton Medical Center | | LABORER | | LABORER |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS ZIP CODE | |
| 13a. STATE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 26 N VINCENT ST | |
| 13b. COUNTY | | BALTIMORE | | 21223 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| 14. FIRST MIDDLE LAST | | 15. FIRST MIDDLE LAST | | 16. FIRST MIDDLE LAST | |
| UNKNOWN | | ALICE ANNE | | 220-14886 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN <input type="checkbox"/> | | 220-14886 | | 223 US CHARLES ST | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G.I. Bleeding & Atherosclerosis | | | | | |
| DUE TO, OR AS, A CONSEQUENCE OF (b) Diabetes mellitus & hypertension | | | | | |
| DUE TO, OR AS, A CONSEQUENCE OF (c) CVA | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (CITY OR TOWN COUNTY STATE) | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 17 Aug. 1985, to 6 Sept. 1985, that (I) (we) last saw the deceased alive on 6 Sept. 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| J.W. Reed M.D. | | | | 9/9/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | |
| J.W. REED | | 611 S. CHAS. ST. BALTO MD | | SEP 9 1985 | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 9-1-85 | | BALTON NATIONAL | |
| 23d. LOCATION (CITY OR TOWN COUNTY STATE) | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| BALTO MD | | SEP 9 1985 | | John Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



252109

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Chester Edmond Mitchell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 1 1985 | | 2b. HOUR
11:03 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
10-25-1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wisconsin | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Baker | 12b. KIND OF BUSINESS OR INDUSTRY
Bakery | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edmond E. Mitchell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary A. Schellpfeffer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | 17. INFORMANT
ADDRESS
Mary C. Mitchell (wife) same address | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY ARTERY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCVD | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
DIABETES - CHRONIC RENAL FAILURE - PERIPHERAL VASC. DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED:
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from JAN 19 75 to 8/14 19 85, that (1) (we) last saw the deceased alive on 8/14 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. Michael Karacuschansky | | DEGREE
MD | | 22c. DATE SIGNED
9-4-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Michael Karacuschansky | | 22e. ADDRESS
300 E. 33rd & Guilford Ave. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9/5/85 | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | 25a. DATE RECD. BY REGISTRAR
SEP 5 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

2
9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 3 and 4, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ACUTE MYOCARDIAL INFARCTION
CORONARY ARTERY DISEASE
ASCVD

DIAGNOSIS - CHRONIC RENAL FAILURE - PERIPHERAL VASC DISEASE

X

8/14 2014
X
8-4-82

253121

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 3 5 2
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | |
|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gudny G. Mitchell | | 2a. DATE KNOWN
OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 9-4 1985 | | 2b. HOUR
M
8:05 a.m. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 31, 1924 | 6. AGE (IN YEARS)
LAST BIRTHDAY
61 YRS. | 7c. DATE
PRONOUNCED
DEAD
9-4 1985 |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
716 WASHINGTON PLACE | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
STATISTICIAN | 12b. KIND OF BUSINESS
OR INDUSTRY
INVESTMENT | |
| 13a. STATE
MARYLAND | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
716 WASHINGTON PLACE 21207 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GUNNAR GJERTSEN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AMY PAULSEN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | 17. INFORMANT
10024 ADDRESS N.Y., N.Y.
KAREN P. MITCHELL 318 W. 77TH ST. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Ethanolism</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b).
DUE TO, OR AS A CONSEQUENCE OF
(c). | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL
SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | DATE
SIGNED 9-4-85 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL
CREMATION | 23b. DATE
SEPT. 6, '85 | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD. | | 25a. DATE REC'D. BY REGISTRAR
SEP 6 1985 | 25b. REGISTRAR'S SIGNATURE
<i>James Gordon Randall</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

131000



268107

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Mitchell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 18, 1985 | | | 2b. HOUR
1207M | | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 27 24 | | 6 AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Michael Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2420 W. Franklin Street 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Mitchell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Gaither | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-14-2102 | | 17. INFORMANT
ADDRESS
Jurlin Mitchell 2420 W. Franklin Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE Cause (a) <u>Cardiopulmonary Arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Hepatic Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hepatocellular Cancer</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 20</u> , 19 <u>85</u> , to <u>Sept 18</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Sept 18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Sandra L. Howard M.D.</u> DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
9-19-85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sandra L. Howard M.D. | | | | | 22e. ADDRESS
1600 S. Charles ST. 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
9/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk. | | 23d. LOCATION
Arbutus, COUNTY Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 4300 Wabash Avenue | | | | | 25a. DATE REC'D BY REGISTRAR
SEP 20 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Sandra L. Howard</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

301802



301802

254053

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) MARY M. MITCHELL | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 5 85 | | 2b HOUR
7 (5AM) |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
2 7 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY)
90 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Maryland 13b COUNTY Baltimore | | 13c CITY OR TOWN
Dundalk | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Daniel Bahr | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Feldmann | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
217-22-0014 | | 17 INFORMANT ADDRESS
Catherine A. Flowers Same as 13c | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) septic shock
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
urinary tract infection | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (this hospital) attended the deceased from 9/4 , 19 85 , to 9/5 , 19 85 , that (we) last saw the deceased alive on 9/5 , 19 85 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Michael J. Fisher | | DEGREE
MD | | 22c DATE SIGNED
9/5/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL FISHER | | 22e ADDRESS
Mercy Hospital Baltimore Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
9/7/1985 | | 23c NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Maryland | | 24 FUNERAL DIRECTOR
NAME ADDRESS
Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 | | | |
| 25a DATE REC'D. BY REGISTRAR
SEP 9 1985 | | 25b REGISTRAR'S SIGNATURE
Rudolph R. Ruck | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Vital Records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

321023



253062

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 5 5

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|---|---|--|
| 2. DECEASED NAME
(TYPE OR PRINT) Tharman Mitchell | | | 2a. DATE OF DEATH
MONTH 9 DAY 2 YEAR 85 | | | 2b. HOUR
6:45 P.M. | | | | | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH 11 DAY 22 YEAR 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
— | | | 12b. KIND OF BUSINESS OR INDUSTRY
— | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
— | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3113 Brighton St 21216 | | | |
| 14. FATHER'S NAME
FIRST Mayo MIDDLE — LAST Mitchell | | | | 15. MOTHER'S MAIDEN NAME
FIRST Corine MIDDLE — LAST Clapps | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | | 16b. SOCIAL SECURITY NO.
244-16-7171 | | 17. INFORMANT
(Sweetie)
Dorothy Mitchell ADDRESS 3113 Brighton Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF
(b) —
DUE TO, OR AS A CONSEQUENCE OF
(c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months since diagnosis
? time prior to diagnosis
month - years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.
Non insulin dependent Diabetes Mellitus, Hypertension, myocardial infarction in past | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
— P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/22 , 19 85 , to 9/2 , 19 85 , that (I) (we) last saw the deceased alive on 9/2/85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
J. Kinney, M.D. | | | | DEGREE
— | | | | 22c. DATE SIGNED
9/2/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Kinney, M.D. | | | | 22e. ADDRESS
Mercy Hospital 301 St Paul St Baltimore, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/9/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest VA | | 23d. LOCATION
CITY OR TOWN Owings COUNTY Mills STATE Md | | 25a. DATE REC'D. BY REGISTRAR
SEP 6 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME William C. March F/H 4300 Wabash Avenue ADDRESS — | | | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.



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274060

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|---|--|---|--|---|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
William MITCHELL | | | 2a DATE OF DEATH
MONTH DAY YEAR
September 22, 1985 | | | 2b HOUR
A
4:58 M | | | | |
| 3 SEX
male | | 4 RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 29 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
612 Baker Street 21217 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
William Mitchell | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Stewart | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
219-01-8711 | | 17 INFORMANT
ADDRESS
Pakota Robinson 301 W. Preston Street | | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.IMMEDIATE CAUSE (a) **Coronary thrombus, left antero descending artery.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) **Acute Myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Acute and Chronic passive congestive of Liver and LUNGS.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 21 19 85 , to September 22 19 85 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on September 22 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Timothy Low, M.D. | | | | DEGREE
MD | | 22c. DATE SIGNED
9/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Timothy Low, M.D. | | | | 612 Baker Street
Baltimore, Maryland | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/27/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Brooks United Meth Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Calvert Co Md | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H Inc West 4300 Wabash Ave | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 26 1985 | | 25b. REGISTRAR'S SIGNATURE
Lelia Robinson-Randall | |

020173

PROFIT

NO. 10

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1000

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275118

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
AGNES MOLTZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 27, 1985 | | 2b. HOUR
2:20 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 16 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
----- |
| 13a. STATE
Maryland | | | 13b. COUNTY
----- | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Martin Naparsteck | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
----- Brocki | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT
ADDRESS
James Buddemeyer 1908 Aliceanne St. 21231 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF
(b) C.O.P.D. A.S.C.V.D.
DUE TO, OR AS A CONSEQUENCE OF
(c) -----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (If this hospital attended the deceased from SEPTEMBER 21, 1985 to SEPTEMBER 27, 1985 , that (If we last saw the deceased alive on SEPTEMBER 27, 1985 that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (If we did not view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Walker Impagliatelli</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/27/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALKER IMPAGLIATELLI M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY BALTO., MD. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Sept 30 '85 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Md. | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler, Inc. | | ADDRESS
21231 | | 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

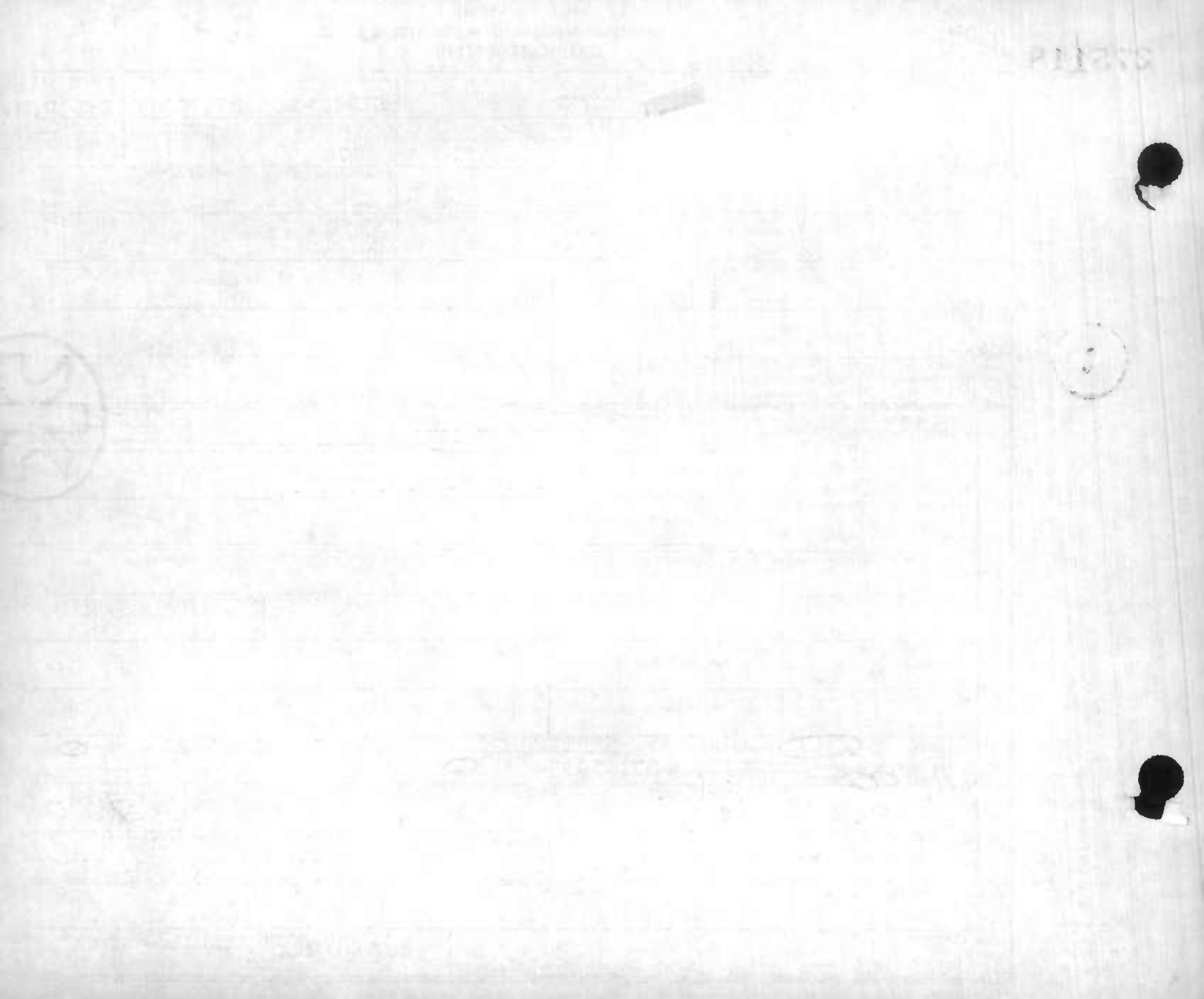
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

| | | | | | | | |
|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HANSEL W. MONROE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-24-85 | | | 2b. HOUR
9:55 A | |
| 3. SEX
male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 12 11 | | 6. AGE [IN YEARS (LAST BIRTHDAY)]
74 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
VA. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oscar Monroe | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-14-2234 | | 17. INFORMANT
Catherine Grooms ADDRESS
Wash, D.C. 3921 Illinois Ave NW | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Heart failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/16 , 19 85 to 9/24 , 19 85 , that (I) (we) lost saw the deceased alive on 9/24 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
BICH T DUONG | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9-24-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BICH T DUONG | | | | 22e. ADDRESS
LUTHERAN HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H, Inc. West | | | | ADDRESS
4300 Wabash Ave | | 25a. DATE REC'D. BY REGISTRAR
SEP 26 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | |

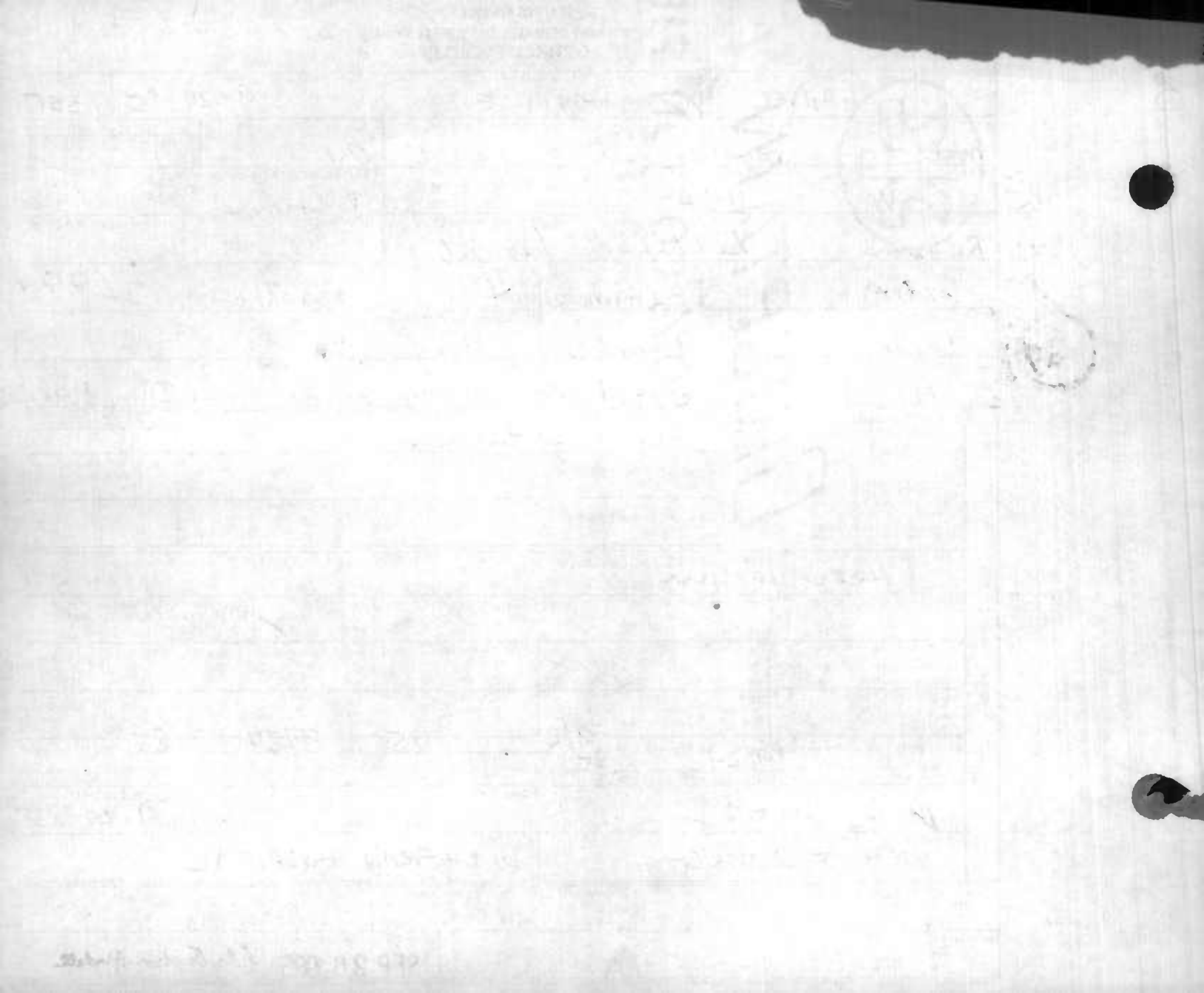
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, signs 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the information must be filled above.

Burial



259212

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Helen M. Montanari | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 07 1985 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
08/ 17/ 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Med.Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Reid-Avery | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
102 Baltimore Ave. 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anthony DeSarro | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria Bontaria | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
217-09-8998 | | 17. INFORMANT
ADDRESS
John J. Montanari 102 Baltimore Ave. 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HASCCVD</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>Insulin Dependent Diabetes</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>October 10, 1980</u> to <u>Sept. 7, 1985</u> , that (I) <u>lost</u> saw the deceased alive on <u>Sept 2, 1980</u> , and that in (my) <u>four</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>lost</u> (did not) view the body after death. | | | | | | | | | |
| 23. SIGNATURE
<u>Benigno R. Lazaro</u> M.D., F.A.C.P. 59 DUNDALK AVE. BA:TO.MD. 21222 | | | | | | 22c. DATE SIGNED
9-11-85 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
09/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Connelly Funeral Home 81 Dundalk | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Wm Davidson Handell</u> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above shows injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Margaret I. Mooney | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPT 06 85 | | | 2b. HOUR
9:59 M | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 27, 1898 | | 6 AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Charwoman | | 12b. KIND OF BUSINESS OR INDUSTRY
Building Cleaning | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2628 Hampden Avenue 21211 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles White | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dora Appleby | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
Dorothy Zepp | | ADDRESS
2646 Hampden Avenue | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/22 , 19 85 to 9/26 , 19 85 that (I) (we) last saw the deceased alive on 9/26 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
M. Keith Rawlings MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
9/26/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. M. Keith Rawlings | | | | | | 22e. ADDRESS
Union Memorial Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
09 30 85 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Burge-Henss Funeral Home, Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | | 25b. REGISTRAR'S SIGNATURE
John S. ... | | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

342051



259182

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 3 6 1

| | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BRUCE William MOORE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09 09 85 | | | 2b. HOUR
11 P M | | | |
| 3. SEX
Male | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
09 20 48 | | 6. AGE (IN YEARS LAST BIRTHDAY)
36 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Graphic Artist | | 12b. KIND OF BUSINESS OR INDUSTRY
Advertisement | |
| 13a. STATE
Md. | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2631 St. Paul Street 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry C. Moore | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hazel E. Morgan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
219-52-4072 | | 17. INFORMANT
ADDRESS
Hazel E. Moore 2631 St Paul St. 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) METASTATIC ADENOCARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) X Months | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Karl Salman | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/9/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KARL SALMAN | | | 22e. ADDRESS
SINAI HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
9-11-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Burgee-Henss Funeral Home 3631 Falls Rd 21211 | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Galia Davidson-Rodriguez | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 541392

| | | | | | | | | |
|--|--|--|--------------|---|--|--|----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Edna | MIDDLE
M. | LAST
Morris | 2a. DATE OF DEATH
MONTH DAY YEAR
9 17 85 | | 2b. HOUR
4 ⁴⁷ a.m. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
04/25/1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Med. Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Melvin Humes | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Georganna Roler | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-20-8720 | | 17. INFORMANT
ADDRESS
21222
Joseph Morris 6905 Brentwood Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Septic</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/16/85</u> , 19 <u>85</u> , to <u>9/17</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Sept 17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Lea Stern MD.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>9/17/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>LEA STERN MD</u> | | | | 22e. ADDRESS
<u>4940 Eastern Ave. Baltimore MD.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
<u>09/19/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gardens of Faith</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore, Md.</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Connolly Funeral Home of Dundalk</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>SEP 18 1985</u> | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3, and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

274048

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FRANCES S. MORRIS | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 12 85 | | 2b HOUR
7:33 P M |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
5 21 21 | 6 AGE (IN YEARS (LAST BIRTHDAY))
64 YRS. | 7 IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
U.S. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | |
| 10 CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fed. Hill Nursing Home | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurses Aid | 12b KIND OF BUSINESS OR INDUSTRY
Nurs. Home | |
| 13a STATE
Md. | | | 13b COUNTY | 13c CITY OR TOWN
Balto. | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b SOCIAL SECURITY NO.
212-80-4313 | 17 INFORMANT ADDRESS
Ms. Pat Robinson 3307 McEldery St. Balto., Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>cardiac arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>renal failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>renal carcinoma</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>1 year</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>congestive heart failure, diabetes mellitus</u> | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>September 3, 19 85</u> , to <u>Sept. 12, 19 85</u> , that (I) (we) last saw the deceased alive on <u>September 9, 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
<u>Carol G. Hooper</u> | | DEGREE
M.D. | | 22c DATE SIGNED
<u>9/16/85</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Carol G. Hooper</u> | | 22e ADDRESS
<u>107 E. West Street, Baltimore, Md. 21230</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b DATE
9/12/85 | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION
CITY OR TOWN COUNTY STATE |
| 24 FUNERAL DIRECTOR
NAME
Anatomy Board | | | ADDRESS
Balto., Md. | | 25a DATE REC'D. BY REGISTRAR
SEP 26 1985 |
| 25b REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | | | |

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RECEIVED
DIRECTOR
MAY 1966



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FOR 10-8-85 D.W.

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 3 6 4

| | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LUCY MORRIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 29 1985 | | 2b. HOUR
06:13AM | | | | | |
| 3 SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 6 16 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
69 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.c. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charlie Jones | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Betty Tripp | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Arrette Cherry 1308 Homewood Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Refractory hypotension
DUE TO, OR AS A CONSEQUENCE OF (b) Probable sepsis
DUE TO, OR AS A CONSEQUENCE OF (c) Gastric Outlet Obstruction
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
~12 hours
~1 day
~2 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 28 , 19 85 , to Sept 29 , 19 85 , that (I) (we) lost saw the deceased alive on Sept 29 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Susan M. Melley | | | | | DEGREE
MD | | 22c. DATE SIGNED
9/29/85 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Susan M. Melley | | | | | 22e. ADDRESS
The Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
10-3-85 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
W.C. MARCH F/H CO. 1101 E. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Randell | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25365

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--------------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Willie Morrison Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-5-85 | | 2b. HOUR
1:30 AM |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
9 8 29 | 6. AGE (IN YEARS LAST BIRTHDAY)
56 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PROVIDENT HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
OLDIN MORRISON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAGGIE McNEAL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) IF YES, GIVE WAR OR DATES
YES | | 16b. SOCIAL SECURITY NO.
237-38-4125 | 17. INFORMANT ADDRESS
SARAH MORRISON 1123 N. CARROLLTON AVE | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio-Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Massive Cerebral Vascular Accident

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

| | | | |
|--|---|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 15, 1985, to Sept. 5, 1985, that (I) (we) lost
saw the deceased alive on Sept. 5, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Alick Dube, M.D. | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
August 5, 1985 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alick Dube, M.D. | 22e. ADDRESS
Provident Hospital
Baltimore, Md. 21215 | | |

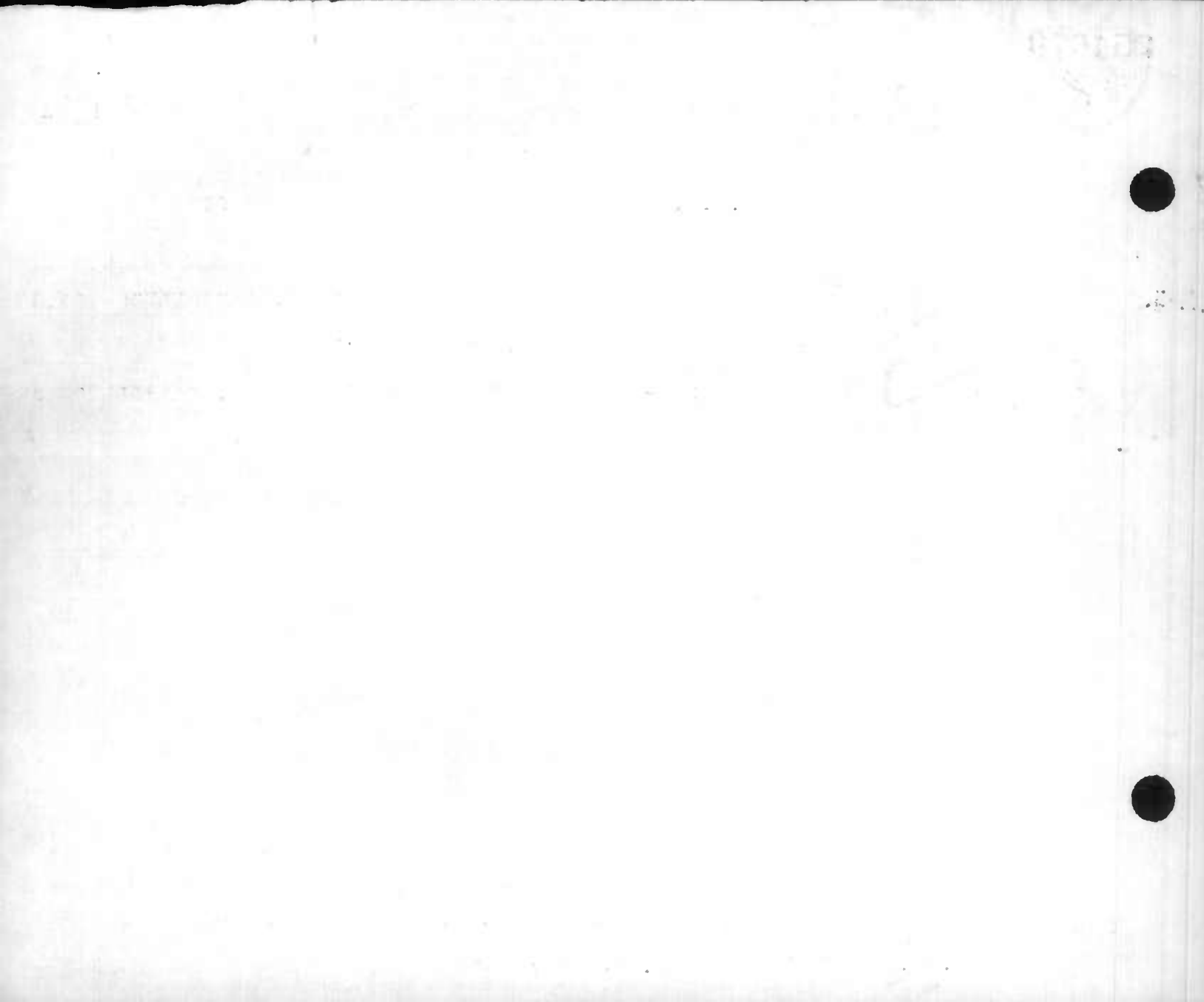
| | | | |
|---|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/10/85 | 23c. NAME OF CEMETERY OR CREMATORY
CROWNSVILLE VA | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CROWNSVILLE MD |
| 24. FUNERAL DIRECTOR
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of one.



269078

FOR 16b, 17, 23d 10/9/85 rj DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE
REGISTRAR
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE J LAST MORRISON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 21, 1985 | | 2b. HOUR
1:59AM |
| 1. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 9 1953 | | 6. AGE (IN YEARS LAST BIRTHDAY)
31 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Oklahoma | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accounting Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Oklahoma 13b. CITY Tulsa | | | 13c. CITY OR TOWN
Tulsa | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2931 East 72nd Place 99999 |
| 14. FATHER'S NAME
FIRST Edmond MIDDLE LAST Morrison | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE LAST Chandler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
----- | | 16b. SOCIAL SECURITY NO.
445-54-5655 | | 17. INFORMANT
Carol Murphy 2931 East 72nd Place Tulsa, Ok. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) METABOLIC ACIDOSIS / HYPOXIA
DUE TO, OR AS A CONSEQUENCE OF (c) CONGENITAL HEART DISEASE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEPTIS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Hour
8 HRS
31 YRS |
| 19a. DATE OF OPERATION
8/29/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CONGENITAL HEART DISEASE | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME - STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/21, 1985, to 9/21, 1985, that (I) (we) lost saw the deceased alive on 9-21-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE | | 22c. DATE SIGNED
9-21-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CASHA | | 22e. ADDRESS
JH# 601 NORTH WOLFE STREET
BALTIMORE, MARYLAND 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-24-85 | 23c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Tulsa, Tulsa, Oklahoma | |
| 24. FUNERAL DIRECTOR
NAME Marzullo Funeral Service ADDRESS Reisterstown, Md. | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | | |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Joseph A. Moscato
<i>Joseph</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 13, 1985 | | 7b. HOUR
2:30 PM | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
3-3-1919 | |
| 6a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Moscato | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Phyllis Piazza | | 12b. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Steelworker | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes. | | 16b. SOCIAL SECURITY NO.
1939-1945 220-01-1064 | | 17. INFORMANT
ADDRESS
Angela Moscato same address | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) **Metastatic Carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on Sept 13 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 27b. SIGNATURE
<i>Robert Arin</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 27c. DATE SIGNED
Sept 13, 1985 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 27e. ADDRESS
Good Samaritan Hospital, Balto, Md. | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. Park, Balto., Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 17 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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(A)

30% COTTON FIBRE

WELFARE



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 3 6 8
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ALBERT J MOSER | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 2 85 | | 2b. HOUR
8:40pm |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 29, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven Veterans Adm. Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Driver | 12b. KIND OF BUSINESS OR INDUSTRY
Heavy Equipment |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Reisterstown | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John B. Moser | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Priscella Shorb | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 214-18-3779 | | 17. INFORMANT
ADDRESS
2130 Old Westminster Pike
Bessie VonGunten Finksburg, Md. 21048 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated metastatic cancer</u>
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Aspiration pneumonia</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>AUGUST 23</u> , 19 <u>85</u> , to <u>SEPTEMBER 2</u> , 19 <u>85</u> , that <u>XX</u> (we) last saw the deceased alive on <u>SEPTEMBER 2</u> , 19 <u>85</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. (Have) (did) (did not) view the body after death. | | | | |
| 23a. SIGNATURE
<u>R. Hesley</u> | | 23b. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 23c. DATE SIGNED
<u>9/2/85</u> |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. Hesley | | 23e. ADDRESS | | |
| 23f. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23g. DATE
Sept. 5, 1985 | 23h. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet. Cem. Owings Mills, Balto., Md. | |
| 24. FUNERAL DIRECTOR
NAME
<u>H. E. Ehrhardt</u> | | 24b. ADDRESS
21117
Owings Mills, Md. | | |

MEDICAL CERTIFICATION

29

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

John

John

Dec. 25, 1941

John

John

Heavy equipment

John, Heavy Equipment, John, Driver

John

John

John

X

John

John

John

John

John

John

John

John

John

John, Heavy Equipment, John, Driver

John, Heavy Equipment, John, Driver

Heavy equipment

John

John, Heavy Equipment, John, Driver

John

John, Heavy Equipment, John, Driver

253082

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|--|--|---|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
PHILLIP A MOSS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 3 85 | | 2b. HOUR
9:00 A M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 19 29 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 8. CITIZEN OF WHAT COUNTRY?
USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Airplane | | 13a. STREET ADDRESS / ZIP CODE
4920 BELAIR ROAD 21206 | | |
| 13b. COUNTY
MARYLAND | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PERCY MOSS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELMA WEST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b. SOCIAL SECURITY NO.
228-32-3443 | | 17. INFORMANT
CHARLOTTE MOSS | | 17. ADDRESS
4920 BELAIR ROAD | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic esophageal CA (Adeno-)
DUE TO, OR AS A CONSEQUENCE OF
(b) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 8/14/85 to 9/3/85 , that (I) (we) last saw the deceased alive on 9/1/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
F. M. G. 10th | | 22c. DATE SIGNED
9/3/85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT D. MATTHEWSON M.D. | | |
| 22e. ADDRESS
3503 N. CHARLES ST BALTO, 21218 | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | | |
| 23b. DATE
9/3/85 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | 24. ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
SEP 06 1985 | | |
| 25b. REGISTRAR'S SIGNATURE
John T. ... | | | | | | |

MEDICAL CERTIFICATION

83

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35

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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RECEIVED

LIBRARY



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 3 7 0

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Mungo Mabel</i> vs. <i>Mable Mungo</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>09/29/85</i> | | | 2b. HOUR
<i>4:25 PM</i> | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>10 13 20</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>64</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>South Caro.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTO. CITY</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>John Deaton MED. CTR.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>N/A</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | |
|---|--|-------------|---|---------------------------------------|--|---|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
<i>808 St. Paul St. 21202</i> | | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Baltimore</i> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Glover Mungo</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Laura Easton</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>no</i> | | | 16b. SOCIAL SECURITY NO.
<i>240-36-4499</i> | | | 17. INFORMANT ADDRESS
<i>Lilly Jones 7906 Aber Rd. Verowa Pa</i> | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Multiple pressure ulcer & sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Recurrent strokes and dementia</i>
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>27 Aug</i> 19 <i>85</i> to <i>29 Sept</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>29 Sept</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>J.W. Reed M.D.</i> | | | | DEGREE | | 22c. DATE SIGNED
<i>9/30/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>J.W. Reed</i> | | | | 22e. ADDRESS
<i>6118 Ches. St. Balt. Md. 21238</i> | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>10-2-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>King</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Randalls Town Md.</i> | |
|--|--|-----------------------------|--|---|--|---|--|

| | | | | | | | |
|--|--|--------------------------------------|--|--|--|---|--|
| 24. FUNERAL DIRECTOR NAME
<i>W.C. MARCH F/H CO.</i> | | ADDRESS
<i>1101 E. North Ave.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>OCT 2 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Jelia Davidson-Randall</i> | |
|--|--|--------------------------------------|--|--|--|---|--|

580033

3

20% COTTON FIBRE

WILEY MAN



260065

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HEZEKIAH MURRAY Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 7, 1985 | | | 2b. HOUR
MIN.
12:35am | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 16 35 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
50 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1312 N. WASHINGTON ST. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HEZEKIAH MURRAY SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESTER WALKER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | | | 16b. SOCIAL SECURITY NO.
218-30-7058 | | 17. INFORMANT
ADDRESS
WILLIAM MURRAY 6717 Laurel Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation
DUE TO, OR AS A CONSEQUENCE OF
(b) atherosclerotic coronary vascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus
Approximate interval between onset and death
60 minutes
5 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>Sept 6</u> 19 <u>85</u> to <u>Sept 7</u> 19 <u>85</u> , that (1) <u>we</u> last saw the deceased alive on <u>Sept 7</u> 19 <u>85</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Walter N. Kernan</i> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
9/7/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Walter N. Kernan | | | | 22e. ADDRESS
600 N. WOLFE STREET BALTO, MD 21205
THE JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9/12/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

RELEASED NON-MEDICAL DR. T. SMITH PER MR. GREGORY

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement is that the certificate be signed by the attending physician, or other person authorized by the hospital or attending physician, within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please send it to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be retained by the funeral director. The funeral director should send the certificate to the State Department of Health and Mental Hygiene for recording and filing. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

8d FY 221 0
MIDWESTERN
22 01 20

100% COTTON FIBER

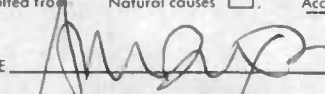
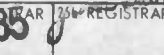
CHIFFON DRESS

263101

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25372 | |
|--|--|------------------|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
FIRST MARY MIDDLE Elizabeth LAST MURRAY | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH 9 DAY 11 YEAR 1985 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH May DAY 21 YEAR 1910 | | 6. AGE (IN YEARS)
75 YRS. | | 7. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH 9 DAY 11 YEAR 1985 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hosp. (STU) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Chemical | |
| 13a. STATE
Md. | | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3120 St. Paul St. 21218 | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE V. LAST Murray | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Naomi MIDDLE Durgin LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
163-07-4929 | | 17. INFORMANT
ADDRESS
Betty Murray Belair, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma complicating seizure disorder</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 9-11- 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject apparently fell over railing. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3120 St. Paul St., Balto. MD | | 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
9-12-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
9-14-85 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Long Green Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co., Balto., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

MEDICAL CERTIFICATION

Elizabeth

has the white May 21 1915

1915

Secretary

May 21 1915

Quinn

May 21 1915

W. V.

Charles

1915-1916

1915-1916

1915-1916

274100

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (SEE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

1- FOR STATE REGISTRAR UNK.#85-73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 3 7 3
REG. NO.

| | | | | | | | | | |
|--|---------------------|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Wayne C. Murray | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9-23 1985 | | | | 2b. HOUR
M AM | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR 3 19 48 | 6. AGE (IN YEARS)
LAST BIRTHDAY 36 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 9-23 1985 | 7d. HOUR
M 12:55 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
700 blk. W. Mulberry Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William C. Murray | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret McCoy | | | | 16. SOCIAL SECURITY NO. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 17. INFORMANT
MARTHA MURRAY | | | | 17. ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot Wound of Chest (unspecified)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 9-23 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject was shot | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
CITY OR TOWN STREET COUNTY STATE
700 blk. W. Mulberry St., Balto., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER
DATE SIGNED 9-23-85 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/29/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Harborside Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD 21227 | | | |
| 24. FUNERAL DIRECTOR
Atari Lee H. Hays | | | | ADDRESS
635 79th Ave SE | | 25a. DATE REC'D. BY REGISTRAR
SEP 27 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

277175

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 7 4

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GERTRUDE ELIZABETH MUTCH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 30 85 | | | 2b. HOUR
1055 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 26 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wyman Park Health System | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Norton | | 16. STREET ADDRESS / ZIP CODE
1627 Inverness Avenue 21230 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-18-1829 | | 17. INFORMANT
Dorothy E. Anderson 1607 Inverness Ave. 21230 | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic obstructive pulmonary disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>cigarette abuse</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 yr. 9 mo. |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 19 <u>85</u> , to <u>9/30</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/30</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Scott Touger, MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>9/30/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Scott Touger, MD | | | | 22e. ADDRESS
3100 Wyman Park Dr Baltimore, MD | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 25375

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

THOMAS

FIRST

MIDDLE

LAST

MUTH

2a. DATE OF DEATH

MONTH

DAY

YEAR

9 13 85

2b. HOUR

9:22 PM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

May

1903

YEAR

6. AGE (IN YEARS LAST BIRTHDAY)

82

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

FRANCIS SCOTT KEY MED. CENTER

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

None

12b. KIND OF BUSINESS OR INDUSTRY

None

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

2700 St. Paul St. 21218

14. FATHER'S NAME

Charles

MIDDLE

P.

LAST

Muth

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

Belle

LAST

Ellinger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

212-07-6612

17. INFORMANT

ADDRESS

21212

Isabelle Muth Meade 202 Rodgers Forge Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

9290

IMMEDIATE CAUSE (a)

HYPOXIC BRAIN DAMAGE

DUE TO, OR AS A CONSEQUENCE OF

(b) SEPSIS

DUE TO, OR AS A CONSEQUENCE OF

(c) PNEUMONIA

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 DAYS

6 DAYS

6 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

STRUCTURAL BRAIN DAMAGE 2° MVA in 1945

19a. DATE OF OPERATION

N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

N/A

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

N/A

21d. INJURY OCCURRED

N/A

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

N/A

21f. LOCATION

STREET

N/A

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

C. Harter

DEGREE

MD

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☒

22c. DATE SIGNED

9/13/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

C. HARTER

22e. ADDRESS

Francis Scott Key Medical Center

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

9-16-85

23c. NAME OF CEMETERY OR CREMATORY

New Cathedral

23d. LOCATION
(CITY OR TOWN)

Baltimore City

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

Mitchell-Wiedefeld Home 6500 York Road 21212

25a. DATE REC'D. BY REGISTRAR

SEP 18 1985

25b. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 of 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

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259198

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased may be buried in the funeral home or in the cemetery within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other treatment of the body. The medical examiner's signature is required on page 4.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report made.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 7 6

| | | | |
|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EUGENE WILLIAM MYERS | | 2a. DATE OF DEATH MONTH DAY YEAR
SEPTEMBER 9, 1985 | |
| 3. SEX
MALE | | 2b. HOUR P M
1:31 P M | |
| 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
11 9 32 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
52 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | |
| 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
918 McDonogh Street 21205 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN MYERS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
KATTIE MIMES | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215 30-0559 | |
| 17. INFORMANT
CHARLENE MYERS | | ADDRESS
1213 N. EDEN STREET | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>assault</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 21g. WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21h. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> , 19 <u>85</u> , to <u>9/9</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>David Herrington</u>
DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED
<u>9/9/85</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>David Herrington</u> | |
| 22e. ADDRESS
<u>Johns Hopkins Hospital Baltimore</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
9/14/85 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Stephen CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | |
| ADDRESS
1101 E. NORTH AVE. | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

523138

2 APR 55 PC 1



276079

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|-----------------------------------|--|---------------------------|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | | 2a DATE OF DEATH | | | 2b HOUR | | | |
| Opal Irene Myers | | | 09-21-85 | | | 4:50 ^A M | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | |
| Female | | White | | 2 13 06 | | 79 YRS | | MONTHS DAYS HOURS MIN. | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| West Virginia | | USA | | | | Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Belair Convalesarium | | Housewife | | Homemaking | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS / ZIP CODE | |
| Maryland | | Baltimore | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 406 Shirley Manor Rd. 21136 | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Willis Beall | | | | Dorothy Nelson | | | | | |
| 16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | |
| No | | | | 220-01-4263 | | Zela Howard 7813 Old Harford Rd. 21234 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CHRONIC CONGESTIVE</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF <u>HEART FAILURE</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> | | | | | | | | | |
| (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>SENILE DEMENTIA</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | |
| | | | P.M. 19 | | | | | | |
| 21d INJURY OCCURRED | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION | | | |
| AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22 I certify that (1) this hospital attended the deceased from <u>November 13, 19 81</u> to <u>September 21, 85</u> that (1) <u>X</u> last saw the deceased alive on <u>Sept 12, 19 85</u> , and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above, and (2) <u>NO</u> did not see the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | 22c DATE SIGNED | |
| <u>[Signature]</u> | | | | | | | | <u>9/21/85</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e ADDRESS | | | |
| Luis Rivera M.D. | | | | | | 50 W Scott Adam Rd., Cockeysville, MD | | | |
| 23a BURIAL, CREMATION, REMOVAL (METHOD) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | |
| Burial | | | 9-23-85 | | Moreland Memorial Pk. | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | | Baltimore, Maryland | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| NAME <u>Lassahn Funeral Home</u> | | | | | | 7401 Belair Rd. BALTO. MD. 21236 | | <u>SEP 27 1985</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove yellow pages. Pages 4 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25377

STORY

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268114

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 7 8
REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) ARLENE T. NADOLNY | | 2a. DATE OF DEATH
MONTH 09 DAY 18 YEAR 85 | | 2b. HOUR
12:15 AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 10 DAY 29 YEAR 32 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALT. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)
MIEMSS - UN OF MD HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST RAUL MIDDLE L. LAST REYNOLDS | | 15. MOTHER'S MAIDEN NAME
FIRST Thelma MIDDLE A. LAST Mohney | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-28-8668 | |
| 17. INFORMANT
Julius J. Nadolny - Baltimore, MD | | 18. ADDRESS
7532 Old Battle Grove Road | | 19. CITY OR TOWN
BALTO | | 20. STATE
MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) SMOKE INHALATION INJURY
DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHO PNEUMONIA | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
DIABETES MELLITUS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR 1:11 P.M. MONTH 08 DAY 28 YEAR 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
CLOSED SPACE SMOKE INHALATION | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Home | | 21f. LOCATION
STREET 7601 Merritt Point Rd. CITY OR TOWN Balto. COUNTY Maryland STATE MD | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, and that (I) (we) saw the deceased alive on _____ 19____, and that (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
HAIKE M MEZGHEBEM | | 22c. DATE SIGNED
9-18-85 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAIKE M MEZGHEBEM | |
| 22e. ADDRESS
MIEMSS | | 22f. QUALIFICATION APPROVED BY MEDICAL EXAMINER
ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/21/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Bel Air Mem. Gardens | | 23d. LOCATION
CITY OR TOWN Bel Air COUNTY Harford STATE Maryland | |
| 24. FUNERAL DIRECTOR
NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222 | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
Richardson-Randall | | | |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

171203

269082

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT CHARLES NEFFERDORF, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 21, 1985 | | | 2b. HOUR
P M
1:30 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
August 2, 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Inspector | | 12b. KIND OF BUSINESS OR INDUSTRY
Koppers | |

| | | | | | | | | | | | |
|--|--|--|--|--|----------------------------|--|---|--|---|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | | 13c. COUNTY
Baltimore | | 13d. CITY OR TOWN
Essex | | 13e. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13f. STREET ADDRESS / ZIP CODE
1-A Eddystone Place 21221 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
U N K N O W N | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
U N K N O W N | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
209-24-0902 | | |
| 17. INFORMANT
ADDRESS
Stephen Nefferdorf 12102 Frederick Road 21043 | | | | | | | | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
20 minutes | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Upper Gastrointestinal Bleeding</u> | | 24 hrs | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Primary Biliary Cirrhosis</u> | | 3 yrs | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from 8/30/85, 19 85, to 9/21, 19 85, that (I) (we) last saw the deceased alive on 9/21, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|--|--|--|--|--------------------------|--|
| 22b. SIGNATURE
<u>C. UMBRICH</u> | | DEGREE | | 22c. DATE SIGNED
9/21 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. UMBRICH MD | | 22e. ADDRESS
Johns Hopkins Hospital | | | |

| | | | | | | | |
|--|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
09-24-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Crest Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Marriottsville Howard Maryland | |
|--|--|-----------------------|--|---|--|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR
HUBBARD FUNERAL HOME 4107 WILKENS AVENUE 21229 | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate can be filed with the attending physician and completely filled in by the funeral director. It should be attached to the burial or cremation permit. The funeral director should also complete page 2 (if there is a burial) and page 3 (if there is a cremation) with the State Dept. of Health and Mental Hygiene prior to final arrangements.
 IMPORTANT: If item 21 is marked "AT WORK" or "NOT WHILE AT WORK", the physician must indicate the nature of the injury or other significant conditions contributing to death in Part 2.

MEDICAL CERTIFICATION

303083

RECEIVED: 1967 JUN 11

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135H

135H



256060

3-11

by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR John L. Neighbours

| | | | | | | |
|---|--|--|---|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John L. Neighbours | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 8 85 | | 2b. HOUR
6:21 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 25 33 | | |
| 6. AGE (IN YEARS (LAST BIRTHDAY))
52 YRS | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 8. CITIZEN OF WHAT COUNTRY?
USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen. Hosp. | | |
| 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Automobile | | 13a. STREET ADDRESS / ZIP CODE
8 Talbot ST 21225 | | |
| 13b. STATE
M.D. | | 13c. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John L. Neighbours | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAE B. Brooks | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | |
| 16b. SOCIAL SECURITY NO.
Korean | | 16c. SOCIAL SECURITY NO.
219-32-1628 | | 17. INFORMANT
ADDRESS
Mae B. Neighbours Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the lung
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/17/ 19 85 to 9/8/ 19 85, that (I) (we) lost
saw the deceased alive on 9/8/ 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Acededo | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/8/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Acededo | | 22e. ADDRESS
3001 S. Hanover ST Balto. Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Park | | |
| 23d. LOCATION
CITY OR TOWN
Glen Burnie | | COUNTY
A.A. | | STATE
Md | | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto Md | | | | 25a. DATE RECD. BY REGISTRAR
SEP 10 1985 | | |
| 25b. REGISTRAR'S SIGNATURE
James M. Anderson-Randall | | | | | | |



262035

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified orally.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|------------------------------------|--|---|--|----------------------------------|------------------|---|---|--------------------------|---|---------------|--|---------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | |
| Everett Harold Nelson | | | 09 | | 08 | | '85 | | | | M | | | | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | |
| Male | | Cauc. | | MONTH DAY YEAR
11 28 1933 | | 52 | | MONTHS DAYS | | HOURS MIN. | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | |
| W. Virginia | | U.S.A. | | | | Baltimore City MD. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | F.S.K. Med. Center | | | | | | | | | | Retired | | Nat'l. Can Co. | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | | Baltimore | | Essex | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 202 Wagner Ave; Essex, Md. 21222 | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| FIRST MIDDLE LAST
Russell Nelson | | | FIRST MIDDLE LAST
Josephine Eiller | | | Yes | | 12/55 - 1/57 | | 213-30-8404 | | Mrs. Dorothy Nestor - | | 220 Altamont Avenue
Catonsville, Md. 21228 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>81</u> , to <u>8-27</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>8-27</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | | |
| <u>F.E. Chatham</u> | | | MD | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| F.E. Chatham | | | 1012 Old North Point Rd. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | | | | | | |
| Burial | | | 09/11/85 | | Evergreen Mem. Gardens | | | Finksburg, | | | | Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | |
| Walter Dabrowski - 1005 Dundalk Avenue 21224 | | | SEP 16 1985 | | | <u>Jane Davidson-Randall</u> | | | | | | | | | | | | |

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Yes
1955 - 1957 113-30-844 Mrs. Dorothy Foster -
Josephine Nelson
Maryland Baltimore 1955
X 204 Kaper Ave. 1955
Baltimore 1955
U.S.A. 1955
11 28 1955 31
00 08 1955



Walter Lebowitz - 1955 113-30-844
Baltimore 1955
1955

268082

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JAMES Burton NEWMAN JR | | | 2a DATE OF DEATH MONTH DAY YEAR
SEPTEMBER 22, 1985 | | 2b HOUR
10:27 A M |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
May 16, 1950 | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
35 | | IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Vice President | | 12b KIND OF BUSINESS OR INDUSTRY
T. Rowe Price Inv. |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Maryland | | | 13b COUNTY
Howard | | |
| 13c CITY OR TOWN
Columbia | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
5313 Catchfly Court 21045 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
James B. Newman Sr. | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jean B. Brocki | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes Vietnam | | 16b SOCIAL SECURITY NO.
213-56-2668 | | 17 INFORMANT
ADDRESS
Marie M. Newman Same as # 13 | |

| | | |
|--|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 minute |
| DUE TO, OR AS A CONSEQUENCE OF
(b) ACUTE PROGRANULOCYTIC LEUKEMIA | | 1 WEEK |
| DUE TO, OR AS A CONSEQUENCE OF
(c) SEPTIC SHOCK | | 1 DAY |

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **RENAL FAILURE, RESPIRATORY FAILURE, DISSEMINATED INTRAVASCULAR COAGULOPATHY**

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 85 , to 9/22 , 19 85 , that (I) (we) lost
saw the deceased alive on 9/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
H. Youssoufian | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
9/22/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HABOP YOUSOUFIAN | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL, BALTIMORE Maryland | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9/25/85 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Terrell M. & Russell C. Witzke Funeral Homes P.A.
5555 Twin Knolls Road, Columbia, Maryland 21045 | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled out, it should be detached for use as the burial transit permit. Their plans to make arrangements for the funeral should be made with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Elizabeth Summers Nichols | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 1, 1985 | | | 2b. HOUR
7:35 AM | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
YEAR MONTH DAY
2/4/1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
85 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
827 Edmondson Ave. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Williams Anderson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Anderson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-09-0829 | | 17. INFORMANT ADDRESS
Mildred Tutt 628 N. Fremont Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Gastrointestinal bleeding and hypovolemia | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Ovarian Carcinoma | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from June 27 , 19 85 , to September 1 , 19 85 , that xx (we) last saw the deceased alive on September 1 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above x (we) did xxxx view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Thomas H Ganey, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
7/1/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas H Ganey, MD | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | 23b. DATE
9-5-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus B.C. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Charles A. Rice FSPA 1300 Eutaw Pl, | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendell | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in) by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

201985

20% COTTON FIBER

100

MADE IN U.S.A.



260008

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILDRED L. NICHOLS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPT. 7, 1985 | | 2b. HOUR
10:30 AM | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 08, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 12. CITY OR TOWN OF DEATH
BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 14a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
WAITRESS | | 14b. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
PENNSYLVANIA | | | | | | 15b. COUNTY | | 15c. CITY OR TOWN
GLEN ROCK | | 15d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 16. FATHER'S NAME
FIRST MIDDLE LAST
EARL HYLE | | | | | | 17. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERTHA EYRING | | | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | | 18b. SOCIAL SECURITY NO.
220-03-4148 | | 19. INFORMANT
ADDRESS
ROBIN LURZ 5105 ANTHONY AVENUE 21206 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metabolic acidosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>neurotic small bowel / ascending colon</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>occluded superior mesenteric artery</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 1/2 days</u>
<u>2 days</u>
<u>2 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<u> crescendo angina / significant coronary artery stenosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
9/6/85 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
peritonitis | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/4/85</u> , 19 <u>85</u> to <u>9/7/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/7</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John E. Merkle M.D. | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/7/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN MERKLE M.D. | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
09-10-85 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEM. PARK | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE, A.A. MARYLAND | | | |
| 24. FUNERAL DIRECTOR
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

2500002



REBUT NOT ON 2500

NO 2500

W/2 2500

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
emitted by the Hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached and sent as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked as item 1B after any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FRANZ A NIEBERBERG | | | | | | REG. NO.
9/6/85 | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 6 85 | | 2b. HOUR
HOURS MIN.
5:50 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 2 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | 7b. HOUR
HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY
Lever Bros. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3103 Chesterfield Ave. 21213 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Bernard Nieberberding | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elizabeth Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
314-03-4151 | | 17. INFORMANT
Ralph Murdy | | | | ADDRESS
5718 Harford Rd. 21214 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart stroke
DUE TO, OR AS A CONSEQUENCE OF, (b) arterio-sclerotic disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) severe arteriosclerosis and ischemia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (g) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) | | 21f. LOCATION (CITY OR TOWN, COUNTY, STATE) | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. Bethune M.D. | | | | 22e. ADDRESS
2300 Putney Valley Rd 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9-9-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE)
Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME
Schimunek Funeral Home, Inc. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

020020



263169

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 5 3 8 6
REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
JIN | | MIDDLE
KOOK | | LAST
NO | | 2a. DATE KNOWN OF DEATH
ESTIMATED
9-13-85 ¹⁹ | | MONTH DAY YEAR | | 2b. HOUR
6:45P ^M | |
| 3. SEX
MALE | | 4. RACE
KOREAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV 19 1931 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
9-13-85 ¹⁹ | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
KOREA | | 7b. CITIZEN OF WHAT COUNTRY?
KOREA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital STU | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
UNK | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
ESSEX | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
620 HIGHLAND RD. 21221 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNK | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNK | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
557-61-8164 | | 17. INFORMANT
ADDRESS
OKKYONG CHONG HOME | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
8120 IMMEDIATE CAUSE (a) Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOURS AM. MONTH DAY YEAR
5:10 PM 9-13-85 ¹⁹ | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Driver of an auto who struck the rear of a tractor/trailer I-95&800ft. North of Essex, Maryland King Ave. | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
hwy. | | | | 21f. LOCATION OF INJURY (CITY OR TOWN, COUNTY, STATE)
BALTO. MD. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
9-14-85 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | | 23b. DATE
SEPT. 15, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
SECURITY PROCESS | | | | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE)
CATONVILLE BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
CONNELLY | | | | ADDRESS
FUNERAL HOME 300 MACE AVE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 18 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3-B, RETURNED TO YOU FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

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100% COTTON

WHITE COTTON
KOREA

100% COTTON

100% COTTON

100% COTTON

100% COTTON
100% COTTON

263137

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 8 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ESTELLE C. NORRIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 17, 1985 | | 2b. HOUR
6:28A M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC. 8, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76
YRS. MONTHS DAYS
IF UNDER 1 YEAR
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
21239 | | 13c. CITY OR TOWN
BALTIMORE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN L. KERBER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY A. MURPHY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-14-0751 | | 17. INFORMANT
ADDRESS
JOSEPH J. NORRIS FALLSTON, MD 21047 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASYSTOLE
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19 80 , to _____, 19 85 , that (I) (we) last saw the deceased alive on _____, 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
James H. Biddison | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/18/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES H. BIDDISON, M.D. | | | | 22e. ADDRESS
6301 N. CHARLES STREET 377-8882 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(USE 23a.)
BURIAL | | 23b. DATE
SEPT. 19, '85 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM E. JOHNSON | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 18 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |
| ADDRESS
8521 LOCH RAVEN BLVD. | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be attached to the funeral home permit. Then please remove outer papers. Pages 3 and 4 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

1950



W M
P O W

COJON FIBER

262041

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SALLY KAY NORRIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 11 85 | | 2b. HOUR
7:25 AM | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 5 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Norman Edwards | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosie Houston | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
413-50-7031 | | 17. INFORMANT
263 McCurley St. - Balto., Md.
James E. Norris #21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
(b) probably acute Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia - stroke - previous Myocardial infarction | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/9 , 19 85 , to 9/11 , 19 85 , that (I) (we) last saw the deceased alive on 9/11 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 27b. SIGNATURE
R. Girgis | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 27c. DATE SIGNED
9/11/85 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
Raafat Y. Girgis | | | | 27e. ADDRESS
St. Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-14-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Howard Md. | |
| 24. FUNERAL DIRECTOR
NAME
G. Trueman Setwars | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

F

2

9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



274135

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|---------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EDWIN NMI NOTTAGE | | | 2a. DATE OF DEATH MONTH DAY YEAR
Sept. 18 1985 | | 2b. HOUR
9:08 M | | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
July 10 1957 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
28 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA, Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
INVALID | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN
MD. BALTIMORE | | 13c. CITY OR TOWN
OWINGS MILLS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
22 South Greene Street 21117 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EDWARD NOTTAGE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CHARLOTT WINTERS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)
N/A | | 17. INFORMANT ADDRESS
Larry Grant - Box 115 Bel Air, Md. | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
acute onset | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Acid obstruction, Abdominal distention | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **cerebral palsy, spastic quadriplegia**

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/18 19 85 to 9/18 19 85 , that (I) (we) lost saw the deceased alive on 9/18/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thom J. O'Loughlin M.D. | | | | DEGREE
MD | | 22c. DATE SIGNED
9/18/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas J. O'Loughlin, M.D. | | | | 22e. ADDRESS
U. Maryland Hosp., 22 S. Greene St., Baltimore Md. | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE
La Plata Charles Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Thomson's Funeral Home Pomonkey, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
9/23/85 | | 25b. REGISTRAR'S SIGNATURE
John F. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, the medical examiner must be notified at once.

251473

REBIT NOTION 2002

WILSON

[Faint, illegible text, likely bleed-through from the reverse side of the page]

269032

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 3 9 0
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BOKIS | | | LAST NUDLER | | | 2a. DATE OF DEATH MONTH DAY YEAR
9-21-1985 | | | 2b. HOUR 6:30 AM | | | |
| 3 SEX
MALE | | | 4 RACE
WHITE | | | 5. DATE OF BIRTH MONTH DAY YEAR
OCT. 4, 1913 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LEVINDALE GERIATRIC HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
OWNER | | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PESACH NUDLER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
TZIVIA SCHTEPPER | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
217-32-8353 | | | |
| 17. INFORMANT
ADDRESS
Apt. I (21209) | | | Mrs. Paula Nudler 3011 Fallstaff Manor Ct. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line from (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA Colon with liver
DUE TO, OR AS A CONSEQUENCE OF metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
July 1985 | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/11 , 19 85 to 9/21 , 19 85 , that (I) (we) last saw the deceased alive on 9/21 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
B. ZAW-LWIN, MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
9-21-85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS
Levin Dale Geriatric Center 21215 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
9/22/85 | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE HEBREW | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
REISTERSTOWN, BALTO., MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS. | | | 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | 25a. DATE
SEP 24 1985 | | | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

580035

20% COTTON YARN

580035

275098

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 3 9 1

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|-------------------------------|--|----------------|--|-----------|--|---------|--|----------|--|---------|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b HOUR | | MIN. | | | |
| Elizabeth | | Null | | | | | | September 28, 1985 | | | | | | | | 7:30 | | PM | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE | | 7 YEARS LAST BIRTHDAY | | 8 UNDER 1 YEAR | | 9 UNDER 24 HRS | | 10 MONTHS | | 11 DAYS | | 12 HOURS | | 13 MIN. | |
| Female | | White | | May 20, 1909 | | 76 | | YRS | | | | | | | | | | | | | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | 10 CITY | | 11 MD. | | | | | | | | | |
| Maryland | | USA | | | | | | City | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | 5220 York Road | | Housewife | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b STATE | | 13c COUNTY | | 13d CITY OR TOWN | | 13e INSIDE CITY LIMITS? | | 13f STREET ADDRESS / ZIP CODE | | | | | | | | | | | |
| Md. | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5220 York Rd. 21212 | | | | | | | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| William | | Stine | | Loda | | Harchelrode | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| no | | 212-05-1321 | | Ms. Alicia Null | | 517 Tunbridge Rd. 21212 | | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| | | | | | | Coronary occlusion | | | | | | | | | | | | | | | |
| | | | | | | CSC/UD | | | | | | | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | Diabetes mellitus | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| | | | | | | 1972 | | Sept 28 85 | | | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from
see the deceased alive on June 24 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | | | | | | | | | | | | | | | |
| | | William G. Helfrich | | MD | | 9/30/85 | | | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | | | | | | | | | | |
| William G. Helfrich, MD | | 5006 Roland Avenue | | Baltimore, Md. | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| Burial | | Oct. 1, 1985 | | Druid Ridge | | Pikesville Balto. Md. | | | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR
NAME | | 24b ADDRESS | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Leonard J. Ruck Inc. | | Baltimore, Maryland | | SEP 30 1985 | | | | | | | | | | | | | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

253117

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) AGNES NUTTER | | 2a. DATE OF DEATH MONTH DAY YEAR 9-5-85 | | 2b. HOUR 3:30AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept 21, 1891 | |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lawrence J Scharnagl | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth ? ? | | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Retired Custodian | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-22-2048 | | 17. INFORMANT ADDRESS Mrs Doris E Blake Same As 13e | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke STROKE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 9-5 1985 to 9-5 1985 , that (1) we last saw the deceased alive on 9-5 1985 , and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If over 48 hours, did not view the body after death.) | | | | | |
| 22b. SIGNATURE Richard J. Jones | | DEGREE MD | | 22c. DATE SIGNED 9/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard J. Jones | | 22e. ADDRESS CHURCH HOSPITAL CORP. 21231 RICHARD JONES M.D. 100 N. BROADWAY BALTO. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/9/85 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Baltimore, Maryland | | | |
| 25a. DATE REC'D BY REGISTRAR SEP 6 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

35

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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DATE: 1972

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1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY HOUR | | 2b. HOUR | |
| APOLLON | | OBATUROW | | Sept 2 85 | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 26 1897 | | 6. AGE (IN YEARS/LAST BIRTHDAY)
88 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2707 ST. PAUL STREET | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
FACTORY | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALEXANDER OBATUROW | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | 13d. STREET ADDRESS / ZIP CODE
2707 ST. PAUL STREET 21218 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
148 26 6092 | | 17. INFORMANT
ALEKSANDER OBATUROW | | ADDRESS
2707 ST. PAUL STREET
BALTIMORE MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute cerebrovascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-Vascular arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dilated myocardium. Atherosclerosis with</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Days</u>
<u>minutes</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Congestive Heart Failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 24 1980</u> to <u>Aug 30 1985</u> , that (I) (we) lost saw the deceased alive on <u>Aug 30 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Henry Armanas M.D.</u> | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
Sept 3/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Henry Armanas M.D. | | | | 22e. ADDRESS
1934 Wilkens Avenue, Baltimore, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9/5/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. ANDREWS CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
DIPPEL FUNERAL HOMES | | | | 7110 BELAIR ROAD
BALTIMORE MARYLAND 21206 | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and sealed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 5 2 5 3 9 4

CERTIFICATE OF DEATH

1- FOR
STATE REGISTRAR Evelyn K. O'Bryan

REG. NO.

| | | | | | |
|---|---------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Evelyn K. O'Bryan</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9-27-85</i> | | 2b. HOUR
<i>12:40 PM</i> | |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 3. DATE OF BIRTH
MONTH DAY YEAR
<i>12 13 1918</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>66</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St. Agnes Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Clerk</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>City</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Louis Kisner</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Rhoda</i> | | 13d. STREET ADDRESS / ZIP CODE
<i>206 Oaklee Village 21229</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>n/a</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>n/a</i> | | 17. INFORMANT
ADDRESS
<i>Vincent J. O'Bryan</i> | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardio resp. failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>metastatic CA lung</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>9/27/85</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>9/16</i> , 19 <i>85</i> , to <i>9/27</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>9/27</i> , 19 <i>85</i> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Rease</i> | | DEGREE | | 22c. DATE SIGNED
<i>9/27/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>GARG</i> | | 22e. ADDRESS
<i>St. Agnes Hospital</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>9/30/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Meadowridge Mem Ph.</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Dorsey Howard Maryland</i> | | 23e. DATE REC'D. BY REGISTRAR
<i>SEP 30 1985</i> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Ambrose Inc. 1328 Sulphur Spring Rd. 21227</i> | | 25. REGISTRAR'S SIGNATURE
<i>Richard Anderson-Randall</i> | | | |

MEDICAL CERTIFICATION

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20% COTTON FIBER

WINDMILL



20%
20%
20%

352032

248104

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 9 5

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Regina c. O'Connor | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 1 1985 | | | 2b. HOUR
5:15 pm | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
December 15, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
D.M.V. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3009 Harview Ave. 21234 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John O'Connor | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Simmons | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-34-4081 | | 17. INFORMANT ADDRESS
James O'Connor 608 Nottingham Rd. 21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma (colorectal)
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Arteriosclerotic Cardiovascular Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 22 19 85 , to Sept 1 19 85 , that (I) (we) last saw the deceased alive on Sept 1 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Evan J. Selsky MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
9/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Evan Selsky MD | | | | | | 22e. ADDRESS
Mercy Hosp. 301 St. Paul Pl. Balto. Md. 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Sep 4 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 3 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

29

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

NOV 10 1953

UNITED STATES DEPARTMENT OF THE ARMY



November 10, 1953

Baltimore City

John

E.A.A.

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Baltimore

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25396
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) NICOLE L. OGLESBY | | | | | | 2a. DATE KNOWN OF DEATH
MONTH <input checked="" type="checkbox"/> DAY 9-10-85 YEAR 19 | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH 7 DAY 22 YEAR 70 | | 6. AGE (IN YEARS LAST BIRTHDAY)
15 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH 9 DAY 10 YEAR 19 | | 7d. HOUR
2:03P
M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
7500 Spencer Rd. 21061 | | | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE Oglesby LAST Oglesby | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Phyllis MIDDLE M. LAST Ruffin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Charles Oglesby 2118 Tucker Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of head
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? 9-3-85 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject found shot | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | | | 21f. LOCATION
STREET 7587 E. Howard Rd. CITY OR TOWN Glen Burnie COUNTY Maryland STATE Md | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED 9-11-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Cremation | | | | 23b. DATE
9/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Cem. | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY Md STATE MD | | | |
| 24. FUNERAL DIRECTOR
NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Wm. C. March</i> | | | |

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

520031



WINTERFIELD

20% COTTON 11:3

263145

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---------------------|--|--|--------------------------------------|--|--|--------|--|--|----------|--|--|------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 7a. DATE KNOWN OF DEATH | | | MONTH | | | DAY | | | YEAR | | | 2b. HOUR | | | | | |
| Alexander John Ogrinz, Jr. | | | | | | | | | | | | 9/ 16/ 85 | | | 19 | | | 85 | | | 2:02 | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | | IF UNDER 1 YR. | | | IF UNDER 24 HRS. | | | 7c. DATE PRONOUNCED DEAD | | | MONTH | | | DAY | | | YEAR | | |
| Male | | | White | | | March 20, 1914 | | | 71 YRS. | | | | | | | | | 9/ 16/ 85 | | | 19 | | | 85 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | NEVER MARRIED | | | WIDOWED | | | DIVORCED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | MD. | | | | | |
| Maryland | | | USA | | | X | | | | | | | | | | | | Baltimore City, | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Baltimore | | | 221 Stony Run Lane | | | Pharmacist | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | |
| Md. | | | | | | Baltimore | | | YES X NO | | | 221 Stony Run Lane J. 1 | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME | | | MIDDLE | | | LAST | | | | | | | | | | | | | | |
| Alexander John Ogrinz Sr. | | | | | | | | | Julia Prochaska | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | | | | | | | | | | | | | |
| no | | | 219-12-6664 | | | Mrs. Camilla V. Ogrinz | | | Same | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | PART I DEATH WAS CAUSED BY: | | | IMMEDIATE CAUSE (a) | | | Arteriosclerotic Cardiovascular Disease | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | (b) | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 70. AUTOPSY? | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | YES NO X | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED | | | 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | | | | | | | | | | |
| | | | P.M. 19 | | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | | | | | AT HOME, STREET, FACTORY, FARM, ETC. | | | STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | | | | |
| 21a. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | Autopsy | | | Inspection | | | Inquiry | | | and in my opinion | | | | | | | | | | | | | | | | | |
| death resulted from: | | | Natural causes | | | Accident | | | Suicide | | | Homicide | | | Undetermined manner | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED | | | 9/16/85 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | Gregory R. Kauffman, M.D. | | | ADDRESS | | | 111 Penn St. | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | CITY OR TOWN | | | COUNTY | | | STATE | | | | | | | | | | | |
| Burial | | | Sept. 19, 1985 | | | Dulaney Valley Memorial | | | Cockeysville | | | Balto. | | | Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| Leonard J. Ruck Inc. | | | Baltimore, Maryland | | | | | | SEP 18 1985 | | | | | | | | | | | | | | | | | | | | |

ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (1))

John - 1911

March 20, 1911

Male

Unmarried

Unmarried

101 Stearns Lane N. 1

Bellevue

Id.

Providence

John

John

John

1911-1912 Mrs. Emily V. Quinn

Id.



NOTICE

Sept. 10, 1911 Duane Valley Hospital, Cochrane, Idaho

Female

Leonard J. Buck Inc. Boise, Idaho

280148

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place this certificate and accompanying pages, 1 and 2, in the envelope provided and mail to the State Dept. of Health and Mental Hygiene along with burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 6525398 | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| FOR
1 - STATE
REGISTRAR | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
MAE Bowers OHAGAN | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09 26 85 | | | | 2b. HOUR
9:55 AM | | | |
| 3. SEX
Female | | 4. RACE
Cau. | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 24 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housework | | 12b. KIND OF BUSINESS OR INDUSTRY
own Home | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3507 Hickory Ave 21211 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur D. Bowers | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rhoda Furkhouser | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
234-01-7711 | | 17. INFORMANT
Shrovie Dellinger | | ADDRESS
Rt 2 Strasburg, VA. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF
(b) Probable massive myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-19-85 to 9-26-85, that (I) (we) last saw the deceased alive on 9-26-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Meenakshi Patel | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
9-26-85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MEENAKSHI PATEL | | | | 22e. ADDRESS
SINAI HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-29-85 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. Paul's Lutheran Church | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Edinburg Shennandoah VA | | | |
| 24. FUNERAL DIRECTOR
NAME
C. Lewis Heikman
Dellinger Funeral Home | | | | ADDRESS
Woodstock, VA | | | | 25a. DATE REC'D. BY REGISTRAR
001 03 005
25b. REGISTRAR'S SIGNATURE
John K. ... | | | |

256013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 3 9 9

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNA M. OLSZEWSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 6 1985 | | | 2b. HOUR
11:45 P.M. | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-13-23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
508 S. Bradford St./21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tilton Beverly | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Goldie Lou New | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
233-30-4457 | | 17. INFORMANT
ADDRESS
James Wilson/33 Ida St. R.I. 02909 | | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>SQUAMOUS CARCINOMA OF ESOPHAGUS</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 5 85</u> to <u>SEPTEMBER 6 85</u> , that (I) (we) lost the deceased alive on <u>9 - 6 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Impagliatelli</i> | | | | DEGREE | | 22c. DATE SIGNED
9/6/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
IMPAGLIATELLI, WALKER | | | | 22e. ADDRESS
100 NORTH BROADWAY
BALTIMORE, MARYLAND 21231 | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/10/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Lilly & Zeiler Inc. 1901 Eastern Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their place remove this page from the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

259105
6th

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|--|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. 8 5 2 5 4 0 0 | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT ONEAL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
9 8 85 | | | 2b. HOUR
6:05 P.M. | | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH MONTH DAY YEAR
6 30 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
64 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, Baltimore, Maryland 21218 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Oscar O'Neal | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Fannie Miles | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
244-12-9594 | | 17. INFORMANT ADDRESS
Ruth O. Neal 465 Manse Court | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) sepsis
DUE TO, OR AS A CONSEQUENCE OF (c)
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/8/85 to 9/8/85 , that <input checked="" type="checkbox"/> (we) lost <input checked="" type="checkbox"/> saw the deceased alive on 9/8/85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | |
| 22b. SIGNATURE R. Hesley MD DEGREE | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
9-8-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. Hesley | | | | | 22e. ADDRESS
VAMC, Baltimore, Maryland 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Owings Mills MD | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
William C. March F/H Inc 4300 Wabash Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

250102

200% cotton

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|--|---|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
ANNIE L. OWENS | | | 2a DATE OF DEATH
MONTH 9 DAY 23 YEAR 85 | | | 2b HOUR
M | | | |
| 3 SEX
FEMALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH 5 DAY 4 YEAR 22 | | 6 AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b CITIZEN OF WHAT COUNTRY?
US | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
CITY MD | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2528 TERRA FIRMA ROAD 21225 | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
MARYLAND | | | 13b COUNTY
BALTIMORE | | 13c CITY OR TOWN
BALTIMORE | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST WILLIE MIDDLE JACKSON LAST AMANDA | | | 15 MOTHER'S MAIDEN NAME
FIRST AMANDA MIDDLE WATKINS LAST ROSELLA MATTHEWS | | | 16 ADDRESS
1108 CHERRY HILL RD. 21225 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | 16b SOCIAL SECURITY NO. | | | 17 INFORMANT
ROSELLA MATTHEWS | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) ANGINA PECTORIS
DUE TO, OR AS A CONSEQUENCE OF
(c) PERNICIOUS ANEMIA
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/11 , 19 85 , to 9/14 , 19 85 , that (I) (we) last saw the deceased alive on 9/14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | 22c. DATE SIGNED
9/26/85 |
| 22b. SIGNATURE
M. M. MENENDEZ | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
9/26/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. M. MENENDEZ, MD. | | | 22e. ADDRESS
5820 YORK RD. BALTO. MD 21207 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
9-27-85 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PK. | | 23d. LOCATION
CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE | | |
| 24 FUNERAL DIRECTOR
NAME
E.L. PHILLIPS | | | ADDRESS
1721 N. MONROE ST. 21217 | | | 25a. DATE REC'D. BY REGISTRAR
OCT 1 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained for 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

100-100000



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 267002
8-11 | | 1. DECEASED NAME
(TYPE OR PRINT) <i>Arturo Pacheco</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>09 17 85</i> | | 2b. HOUR
<i>8⁰⁰ A.M.</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Hispanic</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>08 12 39</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>46</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Peru</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>Peru</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>South Baltimore General Hosp.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Vice President of</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Rice Unruhco Co</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Arturo Pacheco</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Olga Pacheco</i> | | 13e. STREET ADDRESS
<i>3820 Milford Mill Rd. 21207</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>1961-1965 224-58-5052</i> | | 17. INFORMANT
NAME ADDRESS
<i>Baltimore MD 21207</i>
<i>Mrs. Florencia Pacheco 3820 Milford Mill Rd.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis Shock</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acquired Immunodeficiency Syndrome</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Hours</i>
<i>6 months</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/14</i> , 19 <i>85</i> , to <i>9/17</i> , 19 <i>85</i> , that (I) (we) lost
saw the deceased alive on <i>9/17</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Charles Harper M.D.</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Charles Harper</i> | | 22e. ADDRESS
<i>3001 S. Hanover Baltimore, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>9-20-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Westview Memorial Pk.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Catonsville Baltimore MD</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Loring Byers Funeral Directors, Inc</i>
<i>8728 Liberty Rd. Randallstown, MD 21133</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>SEP 19 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in the Division of Vital Records, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 5 and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REPRODUCTION PROHIBITED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25403

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PAUL A. PALUMBO | | | 2a. DATE KNOWN OF DEATH
X MONTH DAY YEAR
9-19-85 19 | | | 2b. HOUR
M | | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
11-18-21 | 6. AGE (IN YEARS)
LAST BIRTHDAY
63 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
9-19-85 19 8:19PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Security | | 12b. KIND OF BUSINESS OR INDUSTRY
Congress Hotel | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Palumbo | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Catherine Gaglio | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
yes WWII | | | | |
| 16b. SOCIAL SECURITY NO.
220-09-0825 | | 17. INFORMANT ADDRESS
Lucy Dames 3726 Bon View Avenue 21213 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell, M.D. | | | TITLE (SPECIFY)
Assistant | | | DATE SIGNED
9-20-85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9-23-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Com. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24. FUNERAL DIRECTOR
Schimmunek Funeral Home, Inc. | | | ADDRESS
3331 Brehms St.
Balto., Md. 21213 | | | 25a. DATE REC'D. BY REGISTRAR
SEP 20 1985 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Gordon R. Riddle | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

1/10

3

2021 COTTON FIBER

DAVID A. BROWN



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

248079

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 18 22a 10/21/85 mtb F#608
 FOR
 1- STATE
 REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|---------|------------------|---|-------------------|---------------------|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE ESTIMATED | | | 2c. DATE PRONOUNCED DEAD | | | 2d. DATE OF DEATH | | |
| LESLIE ANN PANELLA | | | 9-1-85 | | | 9-1-85 | | | 9-1-85 | | | 9-1-85 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | |
| Female | White | Sept. 21, 1953 | 31 YRS. | | | Baltimore City | | | Baltimore | | | St. Agnes Hospital | | |
| 12a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 12b. CITIZEN OF WHAT COUNTRY? | | | 12c. MARRIED | | | 12d. NEVER MARRIED | | | 12e. DIVORCED | | |
| Maryland | | | U.S.A. | | | <input checked="" type="checkbox"/> | | | <input type="checkbox"/> | | | <input type="checkbox"/> | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| Maryland | | | Baltimore | | | Baltimore | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 4008 Twin Circle Way 21227 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| Paul R. Panella | | | Mary Carver | | | No | | | 214-64-9657 | | | David P. Panella Baltimore, Md. 21228 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Narcotism | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | | |
| Margarita A. Korell, M.D. | | | M.D. Assistant | | | | | | 9-2-85 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | |
| Burial | | | 9/4/85 | | | Lakeview Memorial Pk. | | | Sykesville Carroll Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | |
| Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | |
| SEP 3 1985 | | | | | | | | | | | | Jana Davidson-Randall | | |

07/84
25M

BP 1293

DHMH - 17
(VR A15 ME (5))

050265

20% COTTON BLEND

275093

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Bong Nam Park | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 25 85 | | 2b. HOUR
2:10 P.M. |
| 3. SEX
Female | 4. RACE
Oriental | 5. DATE OF BIRTH
MONTH DAY YEAR
January 30, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
KOREA | 7b. CITIZEN OF WHAT COUNTRY?
KOREA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Md | | | 13b. COUNTY
Balto | 13c. CITY OR TOWN
Parkville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jang Chun Choi | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kim | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-02-2204 | | 17. INFORMANT
ADDRESS
Jun Mok Lee - Same as #13e | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio Pulmonary Arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
24 hrs

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Sub arachnoid Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/29/85 to 9/25/85 that (I) (we) last saw the deceased alive on 9/25/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Neil Padgett MD | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
9/25/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Neil Padgett MD | | 22e. ADDRESS
U of Md Hospital 225 Green St 21201 | |

| | | | |
|--|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-27-85 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville, Balto., Md. |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | 25b. REGISTRAR'S SIGNATURE
John Davidson-Henderson |

[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side.]

275066

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM F-3. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

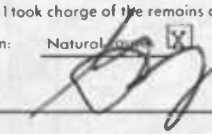
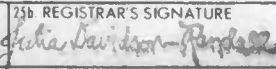
07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (15))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25406

 1- FOR
 STATE
 REGISTRAR

| | | | | | | | | |
|---|---------------------|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
(Alan) Allen | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 9/ 22/ 19 85 | | | 2b. HOUR
6:10 P M | | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
9 3 48 | 6. AGE (IN YEARS)
LAST BIRTHDAY
37 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
9/ 22/ 19 85 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Ray | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Parker | | 13e. STREET ADDRESS
215 Ballou Court 21231 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
216-50-3523 | | 17. INFORMANT ADDRESS
Darlene Parker 338 Madison Ct. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intravenous Narcotism
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED 9/23/85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | ADDRESS
111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
(9/28/85) | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W.C. March F/H Co. 1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR
SEP 27 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

572068



269005

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

| ITEM NUMBER 7a, PER.PH.CALL | | | | STATE OF MARYLAND | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR REGISTRATION 10-1585 D.W. | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | |
| REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| REG. NO. | | | | 5 25407 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
FLORENCE PARKER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
09 22 85 | | 2b. HOUR
1:40 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
01 20 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
COCKVILLE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD | |
| 11. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George Taylor | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sadie Chandler | | 13e. STREET ADDRESS
6717 BONNIE RIDGE DR # T1 | | 13f. ZIP CODE
21209 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-14-3680A | | 17. INFORMANT ADDRESS
Donald Bedford 4538 St George Ave | | 17b. CITY OR TOWN
BALTIMORE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 9/5/85 , 19 85 , to 9/22 , 19 85 , that (we) last saw the deceased alive on 9/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thomas S. Miller, MD | | | | DEGREE
MD | | 22c. DATE SIGNED
9/22/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS S. MILLER, MD | | | | 22e. ADDRESS
GSH | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
9-26-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTO MD. | |
| 24. FUNERAL DIRECTOR NAME
JEFF Miller F.S. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodell | |

280000



280000

266040

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 4 0 8

REG. NO.

| | | | | | | | |
|--|--|--|---|---|----------------------------|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Louise Parker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/15/85 | | 2b. HOUR
9:40 AM | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 1 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mason F Lord Bldg. DIW | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
RICHARD FOWLER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY KILGORE | | 13e. STREET ADDRESS / ZIP CODE
5220 YORK ROAD APT 8I 21212 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-20-9237 | | 17. INFORMANT ADDRESS
ELLA M. HENDERSON 1612 E. 29th ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF:
(b) Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF:
(c) Diabetes Mellitus/Uremic
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign this body after death. | | | | | | | |
| 22b. SIGNATURE
Chadwick Gooding MD | | | | 22c. DATE SIGNED
9/15/85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Chadwick Gooding MD | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9-19-85 | | 23c. NAME OF CEMETERY OR CREMATORY
KING MEMORIAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CO MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | | 25b. REGISTRAR'S SIGNATURE
Galia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

SEP 10 1962

RED 101000



Handwritten notes in the center of the page, including what appears to be a date and some illegible text.

20/21/ X



SEP 10 1962

277082

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 5 2 5 4 0 9

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Doris E. Parrish | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 22 85 | | | 2b. HOUR
4 ⁴⁰ PM | | | | | |
| 1. SEX
F | | 4. RACE
caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 27 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
B. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balt. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
factory | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE 1 IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION | | | 13a. STATE
Md. | | | 13b. CITY OR TOWN
Balto. | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Bryden | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Bull | | | 13e. STREET ADDRESS / ZIP CODE
5114 Arbutus Ave. 21215 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
217-16-8838 | | | 17. INFORMANT
Kathleen Feige 401 N. Luzerne Ave. | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
immed | | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) intracerebral hemorrhage | | | | | | | | 9 days | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)
gangrene of R leg | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NO! WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/14/85, 19____, to 9/22/85, 19____, that (I) (we) last saw the deceased alive on 9/22/85, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Richmond Allan MD | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
9/22/85 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Leonard Lichtenfeld | | | 22e. ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9-25-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Cemetery | | 23d. LOCATION
CITY OR TOWN
Finksburg | | | | |
| 24. FUNERAL DIRECTOR
NAME
John M. Weber & Sons Inc. | | | ADDRESS
401 S. Chester St. | | | 25b. DATE REC'D. BY REGISTRAR 25b. RF
OCT 1 1985 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00346576-5257

TO HOSPITAL OR ATTENDING PHYSICIAN: This is a required document. The death certificate is required to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and co-signatory, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transmission permit. It should be removed from the certificate. Page 4 should be filed with the State Dept. of Health and Mental Hygiene in order to obtain a permit for cremation or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STUDS



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268093

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

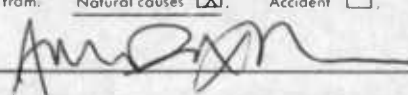
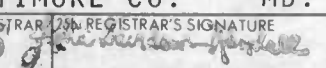
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

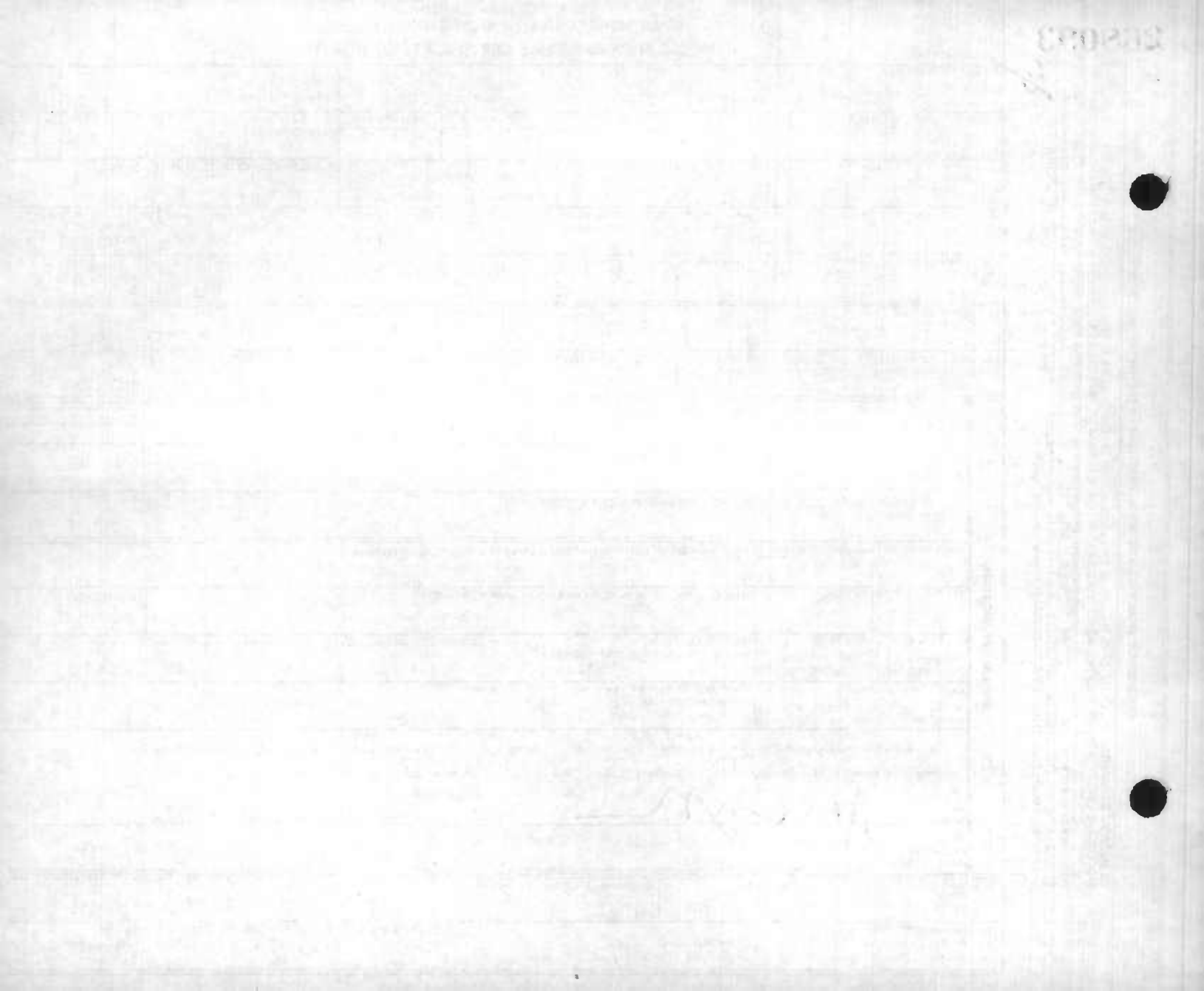
07/84
25M
 BP
DHMH - 17
(VR A15 ME (1))

 1- FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 25410
REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|--|---|--|---|--|---|--|------------------|--|---|--|--|--|--|--|--|--|---------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | FIRST
ALEX | | | | MIDDLE
E. | | | | LAST
PARTYKA | | | | 2a. DATE OF DEATH
KNOWN OF DEATH
ESTIMATED
<input checked="" type="checkbox"/> 9 18 19 85 | | | | 2b. HOUR
AM
3:33 PM | | | |
| 3. SEX
MALE | | 4. RACE
CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV 3, 1918 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
66 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 21 19 85 | | | | 7d. HOUR
AM | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
217 S. Chapel St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
COATER | | | | 12b. KIND OF BUSINESS OR INDUSTRY
NATIONAL CAM | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
MD. | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
BALTIMORE | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
217 S. CHAPEL ST. 21231 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH PARTYKA | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE MENTLEWSKI | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT
ADDRESS
KENNETH PARTYKA 1207 HANDSWORTH PL. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 9-22-85 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
9-24-85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART OF JESUS | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CO. MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
RAYMOND KACZOROWSKI 2525 FLEET ST. 21224 | | | | | | | | | | | | 25. DATE RECEIVED BY REGISTRAR
SEP 23 1985 | | | | 26. REGISTRAR'S SIGNATURE
 | | | | | | | |



260020

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 4 1 1

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MURIEL A. | | MIDDLE | | LAST PATTI | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH | | MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216 30 9142 | | 17. INFORMANT
Anthony Patti, Same | | 13e. STREET ADDRESS / ZIP CODE
1418 W. Cold Spring Lane 21211 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John A. Mask | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Pauline Ferriotti | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216 30 9142 | | 17. INFORMANT
Anthony Patti, Same | | 13e. STREET ADDRESS / ZIP CODE
1418 W. Cold Spring Lane 21211 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEART ATTACK (MYOCARDIAL INFARCT)
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/11, 1985, to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
JMWg~ | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN WICKAN | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
09/14/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn, Balto. Co. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Burgee-Henss Funeral Home | | ADDRESS
3631 Falls Road | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be retained by the funeral director. Page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

020033



CHIEF

NOV 20

266037

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
JAMES A. PAYNE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/13/85 | | | 2b. HOUR
10:25 AM | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
2 10 86 | | 6 AGE (IN YEARS LAST BIRTHDAY)
99 YRS. | | 7a. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7c. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
3a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | 13e. STREET ADDRESS / ZIP CODE
902 Lexington St. Apt. 6 21223 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-03-8572 | | 17 INFORMANT ADDRESS
Constance Payne 816 Cator Avenue | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
L. CURTIS | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
9/18/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEAHUVINA CURTIS | | | 22e. ADDRESS
LUTHERAN HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
9/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | |
| 24 FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | | 25b. REGISTRAR'S SIGNATURE
John Burdick | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

SECRET



253033

ITEM NUMBER 190, PERMITS, CASE

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Baby Girl Pearce</u> | | | 2a. DATE OF DEATH
MONTH <u>8</u> DAY <u>17</u> YEAR <u>85</u> | | 2b. HOUR
<u>9:30 AM</u> |
| 3 SEX
<u>Female</u> | 4. RACE
<u>White</u> | 5. DATE OF BIRTH
MONTH <u>8</u> DAY <u>16</u> YEAR <u>85</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. <u>—</u> MONTHS <u>—</u> DAYS <u>—</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MD USA</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>CITY</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>CITY</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>UNIV OF MD HOSP BAL MD</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>N/A</u> | 12b. KIND OF BUSINESS OR INDUSTRY
<u>N/A</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>MD</u> 13a. COUNTY <u>N/A</u> | | 13b. CITY OR TOWN
<u>AD.</u> | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13. STREET ADDRESS / ZIP CODE
<u>13 ELMRIDGE ROAD 21012</u> | |
| 14. FATHER'S NAME
FIRST <u>Douglas</u> MIDDLE <u>Pearce</u> LAST <u>Pearce</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>BRENDA</u> MIDDLE <u>Lynne</u> LAST <u>Pearce</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NA</u> | | 16b. SOCIAL SECURITY NO.
<u>NA</u> | | 17. INFORMANT
ADDRESS
<u>13 ELMRIDGE RD ARNOLD MD 21012</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral pneumothorax</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Immature lungs and hyaline membrane disease</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>PREMATURITY - 26 weeks</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>SEPSIS, HYPOTENSION, PERINATAL ASPHYXIA</u> | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>None</u> | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING TO CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)
<u>N/A</u> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>N/A</u> 19 <u>85</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
<u>N/A</u> | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/>
<u>N/A</u> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u>N/A</u> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<u>N/A</u> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4:50 AM 8/16, 1985</u> to <u>9:30 AM 8/17, 1985</u> , that (I) (we) last saw the deceased alive on <u>8/17, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>L. J. Gopalakrishnan MD</u> | | | | 22c. DATE SIGNED
<u>8/17/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>L. J. GOPALAKRISHNAN</u> | | | | 22e. ADDRESS
<u>GICU, UNIV OF MD HOSPITAL</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>Removal</u> | | 23b. DATE
<u>8/23/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Anatomy Board</u> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>BALTO., MD.</u> | | 23e. DATE RECEIVED BY REGISTRAR
<u>AUG 29 1985</u> | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Anatomy Board</u> ADDRESS <u>Balto., Md.</u> | | | | | |

MEDICAL CERTIFICATION

1
2

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

269117

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 4 1 4

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Florence Pearson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 19, 1985 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
11 26 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
731 E. 20th St. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hart Wilkens | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eleanor Underdue | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-82-1124 | 17. INFORMANT
ADDRESS
Florence Francis 762 Barlett Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Feb 80 9/19 85 | | | |
| 22a. I certify that (I) (this hosp. staff) attended the deceased from 8/23 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
D. V. Lindenstruth | | | | | 22c. DATE SIGNED
9/19/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. V. Lindenstruth | | | | | 22e. ADDRESS
827 Linden Ave 21201 |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/27/85 | 23c. NAME OF CEMETERY OR CREMATORY
Family Plot | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Valentine Va. | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These permits remove casket carriers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

200117

RECEIVED 10/10/52

1

SEP 24 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75 25415

REG. NO.

| | | | | |
|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
John PENN | | 2a. DATE OF DEATH
MONTH DAY YEAR
09-18-85 | | 2b. HOUR
P.M. |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
03-25-04 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
81 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY
N/A |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Phillip | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maggie McLean | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | 16b. SOCIAL SECURITY NO.
213-12-8663 | | 17. INFORMANT
John Penn 3504 West Cliff Ave. Va 23222
Admission form - Bon Secours Hospital |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC ADENOCARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/14 1985 to 9/18 1985, that (I) (myself) saw the deceased alive on 9/17 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
John Sitavins | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN SITAVINS | | 22e. ADDRESS
BALT. MD 21223
10 NORTH PAYSON ST. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9/23/85 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansdowns A.A. Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
CHAS. A. RICE FSPA 1300 Eutaw Place | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall |

MEDICAL CERTIFICATION

100-100000

PLANT

NO.

DATE

1. Name of plant or animal

2. Locality

3. Date of collection

4. Name of collector

5. Name of institution

6. Name of person to whom sent

7. Name of person who made report

8. Name of person who made examination

9. Name of person who made description

10. Name of person who made illustration

11. Name of person who made analysis

12. Name of person who made measurement

13. Name of person who made dissection

14. Name of person who made preservation

15. Name of person who made mounting

16. Name of person who made labeling

17. Name of person who made archiving

18. Name of person who made distribution

19. Name of person who made publication

20. Name of person who made exhibition

21. Name of person who made loan

22. Name of person who made return

263021

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 4 1 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary Penn | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/13/85 | | | 2b. HOUR
7:40 AM | | | |
| 3 SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
04/05/20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hosp of Baltimore | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Finksburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2716 Mohawk - 21048 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Geo Hale | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine known | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
214-24-619 | | 17. INFORMANT
ADDRESS
Rose A. Machall - 2716 Mohawk & | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Renal Failure | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
25 min. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(# EITHER NOTE BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4:19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12 , 19 85 , to 9/13 , 19 85 , that (I) (we) lost
saw the deceased alive on 9/13 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
RE Perry MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
9/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RE Perry, M.D. | | | | 22e. ADDRESS
Sinai Hosp of Baltimore, Balt, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE
9/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Crowdville, VA | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crowdville MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Carol 1712 W. North Ave | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like 'from', 'to', and 'the' are faintly visible.]

MEDICAL CERTIFICATION

DHMM - 16 60M 7/B4
(VRA 15, 4)

730635



SEP 24 1982

263036

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 5 4 1 8

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FANNIE ELSIE PERRY | | | 2a DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 13, 1985 | | | 2b HOUR
01:00 am | | | |
| 3 SEX
Female | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 6 03 | | 6 AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
MD | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
1421 E. Lafayette Ave. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Snipes | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Burke | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
No | | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-01-4107 | | 17 INFORMANT
ADDRESS
Sara Douglas 3935 Flowerton Rd. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ANOXIC ENCEPHALOPATHY</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Ventricular Fibrillation</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minute (0-5)
12 days
12 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>8/30, 1985</u> to <u>9/13, 1985</u> , that (I) (we) last saw the deceased alive on <u>9/13, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
Daniel L. Clemens, MD, PhD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Daniel L. Clemens md, PhD | | | | | | 22e ADDRESS
JNH 600 N WOLFE ST. BALTO, MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9/17/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co. MD | | |
| 24 FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
J. W. Harrison | |

MEDICAL CERTIFICATION

10

35

1

2

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 4 1 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES PERRY | | | 2a. DATE OF DEATH
MONTH 9 DAY 29 YEAR 85 | | | 2b. HOUR
M | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH 10 DAY 22 YEAR 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) SC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1834 W FRANKLIN ST | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1834 W FRANKLIN ST 21223 | |
| 14. FATHER'S NAME
William Perry | | | | 15. MOTHER'S MAIDEN NAME
Eugenia 14/108 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Carrie Perry 1834 W FRANKLIN ST | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardio Pulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Chronic heart failure**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Thromb. Hb. 14 G**

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/2/85 to 10/9/85 , that (I) (we) last saw the deceased alive on 10/2/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr. [Signature] MD | | | | DEGREE | | 22c. DATE SIGNED
10/11/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Francisco F. [Signature] | | | | 22e. ADDRESS
1840 W. Belts St Baltimore MD 21223 | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
10/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
MTA Union | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD 21230 | |
| 24. FUNERAL DIRECTOR
NAME Planhall P. [Signature] ADDRESS 1635 N 9th St | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



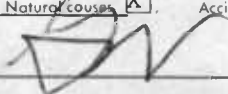
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252121

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25420 | |
|---|--|------------------|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
LaCarl LAMONT Perry | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
9 3 19 85 | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
7 8 85 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
0 YRS. 2 | | 7. IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
9 3 19 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
BALTIMORE | | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
2208 N. CALVERT ST. 21218 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CARL ROSS PERRY | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CYNTHIA SMITH | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
N/A | | | | 17. INFORMANT ADDRESS
CYNTHIA SMITH 2208 N CALVERT ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Sudden Infant Death Syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural Causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | | | | DATE SIGNED
9/3/85 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
9/6/85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | | |
| 23d. LOCATION CITY OR TOWN
ANN ARUNDAL CO. | | | | 23e. COUNTY
MD | | | | 23f. STATE | | | |
| 24. FUNERAL DIRECTOR NAME
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

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WINDMILL
SPLIT-MOTION, 1/2 C2

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 4 2 1

FOR
1. STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|-----------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) William Person | | | 2a. DATE OF DEATH
MONTH 9 DAY 3 YEAR 85 | | 2b. HOUR
11:48 PM |
| 3. SEX
MALE | 4. RACE
NEGRO | 5. DATE OF BIRTH
MONTH 2 DAY 22 YEAR 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
FRANKLINTON, NC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PROVIDENT Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | 12b. KIND OF BUSINESS OR INDUSTRY
STEEL | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE PENNA 13b. COUNTY PHILA 13c. CITY OR TOWN PHILA | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST BENJAMIN MIDDLE F. LAST PERSON | | | 15. MOTHER'S MAIDEN NAME
FIRST EVELYN MIDDLE Williams LAST WILLIAMS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
162-01-0170 | | 17. INFORMANT
DR. Thelma BANDO | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive and respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of lung | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR: A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9.3 19 85 to 9.3 19 85 , that (I) (we) lost
saw the deceased alive on 9.3 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Raul Lopez | | DEGREE
MD | | 22c. DATE SIGNED
9.3.85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Raul Lopez MD | | 22e. ADDRESS
2600 Liberty Way Rd | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
9/10/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. PEACE Cemetery | |
| 23d. LOCATION
CITY OR TOWN PHILA COUNTY PHILA Co. STATE PA | | 24. FUNERAL DIRECTOR
NAME PERRY Funeral Home Inc ADDRESS 19121 Philadelphia PA | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

4. The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

5. The fifth part of the report deals with the cultural situation of the country. It is a very interesting and informative study of the country's cultural development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's cultural development.

6. The sixth part of the report deals with the environmental situation of the country. It is a very interesting and informative study of the country's environmental development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's environmental development.

7. The seventh part of the report deals with the international situation of the country. It is a very interesting and informative study of the country's international development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's international development.

8. The eighth part of the report deals with the future of the country. It is a very interesting and informative study of the country's future development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's future development.

270087

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Elizabeth Hain Peterson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 21, 1985 | | | 2b. HOUR
11:35 PM | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
08-07-1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Agnes Hospital 21229 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. CITY OR TOWN
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
19 Cedarwood Rd. 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James M. Haines | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sallie Kirkwood | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
215-05-9053 | | | 17. INFORMANT
ADDRESS
Estelle Nuttall 19 Cedarwood Road 21228 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CORONARY ATHEROSCLEROSIS</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>SEPT 18, 1985</u> to <u>SEPT 21, 1985</u> , that (we) lost saw the deceased alive on <u>SEPT 21, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Bert F. Morton</u> M.D. | | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
9/22/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>BERT F. MORTON</u> | | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9-25-85 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Johns Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ellicott City, MD 21043 | | |
| 24. FUNERAL DIRECTOR
NAME
MacNabb Funeral Home | | | | | | ADDRESS
Catonsville, Md | | 25a. DATE REC'D. BY REGISTRAR
SEP 25 1985 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>John Anderson</u> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and the certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

570075



275134

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 4 2 3

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|-------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Wallace P. Peterson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 11 85 | | 2b. HOUR
5p.m. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 5 37 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48
YRS MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
(disabled) | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lee Peterson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosie Green | | 16. STREET ADDRESS / ZIP CODE
4311 Old York Rd. 21212 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-20-3285 | | 17. INFORMANT
ADDRESS
Ms. Della Holland 519 Garland Rd. Salisbury, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pancreatic cancer</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>jaundice</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>NA</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION
<u>NA</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>NA</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(CHECKER, INQUIRY MEDICAL EXAMINER)
<u>NA</u> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY FROM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-11-85</u> to <u>9-11-85</u> that (I) (we) last saw the deceased alive on <u>9-11-85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Janine Good</u> | | | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>9-11-85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Janine Good</u> | | | | 22e. ADDRESS
<u>Union Memorial Hosp. Balto Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
9/15/85 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 26 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Johia Davidson-Rendell</u> | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or entombment.



259091

Items 18-22a 10/21/85 mtb F#608

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

25424

1- STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | | 2b. HOUR | |
| Loretta | | | | | | Pettaway | | 9-8 | | 19 | | 85 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR | |
| FEMALE | BLACK | March 27, 1958 | | 27 YRS. | | | | 9-8 | | 19 | | 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| NORTH CAROLINA | | US | | WIDOWED | | DIVORCED | | Baltimore City, | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | 4640 Reisterstown Road | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4640 REISTERSTOWN ROAD | | 21215 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| JAMES | | PETTAWAY | | Willie | | Mae | | WHITE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| NO | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: Cerebellar Hemangioblastoma | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | |
| | | | | M.D. Assistant MEDICAL EXAMINER | | | | | | 9-9-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| Gregory R. Kauffman, M.D. | | | | 111 Penn St., Balto., Md. | | | | | | 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| REMOVAL | | | | 9-11-85 | | DANCY MEM. CEMT. | | | | TARBORO N. CAROLINA | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME | | | | ADDRESS | | | | | | | | | |
| E.L. PHILLIPS | | | | 1721 N. MONROE ST. | | | | SEP 13 1985 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #1. PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

100025

20% COTTON 1955

UNION MILK CO.



259169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8525425

REG. NO.

| | | | | | |
|---|--|--|---|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| John R Petza | | 9 11 85 | | 6 ⁴⁶ a.m. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Male | Caucasian | MONTH DAY YEAR
6 18 06 | 79 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | U.S.A. | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Francis Scott Key Hospital | Machinist | | Amer. Can | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3316 Foster Ave./21224 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
Joseph Petza | | FIRST MIDDLE LAST
Mary Hartka | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 213-10-1348 | | John Petza 4748 Shamrock Ave. 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial Infarction | | | | | hours |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/9 to 9/11 1985, that (I) (we) lost saw the deceased alive on 9/11/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Richard Goldman MD | | 22c. DATE SIGNED
9/11/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Richard Goldman MD | | FSKMC 4940 Eastern Ave Baltm D. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/14/85 | | Sacred Heart Cem. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Lilly & Zeiler Inc. | | 700 S. Conkling St. | | SEP 13 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John A. Schickel | |

BP

1911



260141

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| LEWIS | | PEYTON | | 8 | | 7 | | 85 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | MONTH DAY YEAR
5 22 17 | | 68 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | U.S. | | | | Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Balto. | | 1015 Cathedral St. | | Owner | | Grocery Store | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1015 Cathedral St. 21201 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | |
| | | | | 16b. SOCIAL SECURITY NO. | | | | | |
| | | | | 17. INFORMANT ADDRESS | | | | | |
| | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| | | | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>MI</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>MI</u> | | | | | |
| | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>MI</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/5/85</u> to <u>8/8/85</u> , that (I) (we) lost
saw the deceased alive on <u>8/5/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| | | | | MD | | 9/5/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | | |
| Frank R. | | Thun of And Hosp Balto MD | | Removal | | 23b. DATE | | | |
| | | | | 8/8/85 | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Anatomy Board | | Balto., Md. | | SEP 11 1985 | | Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 4 2 7
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Glen F Phillips | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/14/85 | | | 2b. HOUR
6 A.M. | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 11 47 | | 6. AGE (IN YEARS LAST BIRTHDAY)
38 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ of MD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self-employed | | 12b. KIND OF BUSINESS OR INDUSTRY
Builder | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MD 13b COUNTY WICOMICO 13c CITY OR TOWN Millersville | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
P.O. Box 212 RS W. 1st St MD 21201 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRED L. PHILLIPS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edith L. Phillips | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, IF UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO
214-46-4421 | | 17. INFORMANT
ADDRESS
CONNIE LEWIS, WELLSBORO, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(b) Ruptured Tubercular Aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs.
24 hrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13, 19 85, to 9/14, 19 85, that (I) (we) last saw the deceased alive on 9/14, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
F.H. Geisler | | | | | | DEGREE
MD | | 22c. DATE SIGNED
9/14/85 | |
| 22d. PHYSICIAN'S NAME (IF OTHER) | | | | | | 22e. ADDRESS
22 So Greene St Baltimore MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
9-18-85 | | 23c. NAME OF CEMETERY OR CREMATORY
BETHEL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WELLSBORO WICOMICO MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Charles W. Hastings SELBYVILLE, DE | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 20 1985 | | 25b. REGISTRAR'S SIGNATURE
Sue Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARIAN IDELLA PHILLIPS | | | 2a. DATE OF DEATH MONTH DAY YEAR
09 16 85 | | 2b. HOUR
9 A M |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH MONTH DAY YEAR
09 25 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHN DEATON MEDICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DOMESTIC | 12b. KIND OF BUSINESS OR INDUSTRY
PRIVATE FAMILY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MARYLAND | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
704 GOLD STREET, 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CHARLES R. PHILLIPS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
COURTNEY TATE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-18-3682 | | 17. INFORMANT ADDRESS
MARGARET E. PHILLIPS, 704 GOLD STREET | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular accident</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)
<u>Cardiovascular accident</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> 19 <u>85</u> to <u>9/16</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/13</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Amey Gagne MD</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>16 Sep 85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. C. GAWNE MD | | 22e. ADDRESS
611 S Charles St BALT MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN CEMETERY | |
| 23d. LOCATION
BALTIMORE MARYLAND | | STATE | | | |
| 24. FUNERAL DIRECTOR
NUTTER & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PARKWAY, BALTO., MD 21216 | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified of police.

BP



259165

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|--|--|--|--|
| FOR
1- STATE
REGISTRAR | | 5 2 5 4 2 9 | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NATHANIEL A PHILLIPS | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 6 85
2b. HOUR
8:40PM | |
| 3. SEX
M | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
2 8 20 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
AIRPORT, VA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 6. AGE (IN YEARS (LAST BIRTHDAY))
65
IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PAINTER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | 13b. COUNTY | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES / PHILLIPS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDITH / HELM | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
232-24-7171 | |
| 17. INFORMANT
ADDRESS
ANNA C. PHILLIPS 3628 LUCILLE AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIAL MIA
DUE TO, OR AS A CONSEQUENCE OF
(c) RENAL DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8:00 - 8:15PM
8:15PM | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
ENCEPHALOPATHY | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 3, 19 85, to SEPT 6, 19 85, that (I) (we) last saw the deceased alive on SEPT 6, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
John Thomas Evelius | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
9/6/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN THOMAS EVELIUS | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/11/85 | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, Md. |
| 24. FUNERAL DIRECTOR
NAME
WM. J. SPICER F/H | ADDRESS
1639 N. BROADWAY | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | 25b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

223162



260013

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT) William M PHILLIPS | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 10 85 | | 2b HOUR
6:00 am |
| 3 SEX
Male | 4 RACE
Caucasian | 5 DATE OF BIRTH
MONTH DAY YEAR
9 23 26 | | 6 AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MINS. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oklahoma | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY Medical Center | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machine Opr. | | 12b KIND OF BUSINESS OR INDUSTRY
J.J. Abbott Co |
| 13a STATE
Maryland | | | 13b COUNTY
Baltimore | 13c CITY OR TOWN
Baltimore | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
William Phillips | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clementine Stennett | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO.
444-18-7808 | | 17 INFORMANT ADDRESS
Pauline Phillips, Wife, Same as above | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Septic shock
DUE TO, OR AS A CONSEQUENCE OF
(c) staphylococcal bacteremia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 minutes
4-5 days
4-5 days |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
pulmonary Fibrosis | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 9-3 , 19 85 , to 9-10 , 19 85 , that (I) (we) lost
saw the deceased alive on 9-10 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Barry W. Brosfield | | | | 22c DATE SIGNED
9-10-85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Barry W. Brosfield | | | | 22e ADDRESS
6503 Carlewicke Ct., Sykesville, MD. 21784 | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
9/13/85 | | 23c NAME OF CEMETERY OR CREMATORY
Crownsville Vet. | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
Crownsville, Md. | | | | | |
| 24 FUNERAL DIRECTOR
NAME
SCHIMUNEK FUNERAL HOME, Balto, Md. 21213 | | 25a DATE RECD. BY REGISTRAR 25b REGISTRAR'S SIGNATURE
SEP 13 1985 Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

2

9

1

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed with the funeral director. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

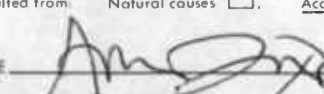
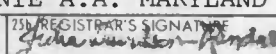
THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201. IT SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH.

277146

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25431
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|---|------------------|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILBUR HARRY PHYLES, JR. | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> MONTH DAY YEAR
SEPT 30 19 85 | | | 2b. HOUR
M
A | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 2, 1956 | 6. AGE (IN YEARS)
LAST BIRTHDAY)
28 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
SEPTEMBER 30 19 85 | 7d. HOUR
M
A
8:10 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO. MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY
TELEST. ELECT INST. |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
ARNOLD | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
1413 MARINER DRIVE 21012 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILBUR H. PHYLES, SR. (LIVING) | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DORIS V. UTZ (LIVING) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1.29 74/4.8.75 220.66.2001 | | 17. INFORMANT
ADDRESS
MRS. SUSAN J. PHYLES (WIFE) SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8150 IMMEDIATE CAUSE (a) Thoracic trauma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2:41 PM 9-30- 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Driver of auto/fixed object impact. | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
New Tick Neck & Mountain Rds., Anne Arundel, MD | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED
9-30-85 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
OCTOBER 03, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEMORIAL PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE A.A. MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 2 SHOULD BE FILED (WITHIN 72 HOURS) AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATION



Oct 3 1900

270091

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>First</u> <u>Middle</u> <u>Last</u>
<u>Dalton</u> <u>C.</u> <u>Pyle</u> <u>File</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>16</u> <u>Sept</u> '85 | | 2b. HOUR
<u>2218</u> M |
| 3. SEX
<u>M</u> | 4. RACE
<u>Caucasian</u> | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>05</u> <u>01</u> <u>21</u> | | 6. AGE (IN YEARS (LAST BIRTHDAY))
<u>64</u> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(COUNTRY)
<u>PA</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore</u> <u>City</u> MD | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Univ. of MD Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>co-worker</u> | 12b. KIND OF BUSINESS OR INDUSTRY
<u>septic tank</u> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>MD</u> 13b. CITY OR TOWN <u>Washington</u> 13c. COUNTY <u>Hagerstown</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<u>2535 Arden Rd / 21740</u> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Russell M. Pile</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Ruth Carver</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>yes</u> | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>W.W.II</u> | 17. INFORMANT
ADDRESS
<u>Charr Dorothy Pile, Hagerstown, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hemorrhagic Shock</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Acute Aortic Dissection</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF:
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 min</u>
<u>6 hrs</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION
<u>16 Sept '85</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Acute Aortic Dissection</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>16 Sept 1985</u> to <u>16 Sept 1985</u> , that (I) (we) last saw the deceased alive on <u>16 Sept 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death. | | | | | |
| 22b. SIGNATURE
<u>F. Clark Sauls</u> | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<u>16 Sept '85</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>F. CLARK SAULS MD</u> | | 22e. ADDRESS
<u>22 S. Greene St / Baltimore</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>burial</u> | 23b. DATE
<u>Sept. 19, 1985</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rest Haven Cemetery</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Hagerstown, Wash. Maryland</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>MINNICH FUNERAL HOME</u> | | ADDRESS
<u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u> | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 23 1985</u> 25b. REGISTRAR'S SIGNATURE <u>John E. ...</u> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper tags, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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263029

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 4 3 3
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|----------------------------|--|--------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | XX MONTH DAY YEAR | | 2b. HOUR | |
| BARBARA E. PINKNEY | | | | | | | | 9-13-85 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE
PRONOUNCED
DEAD | | 2d. HOUR | |
| Female | Black | 3 12 40 | | 45 YRS. | | | | | | 9-13-85 | | 1:20A | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MD | | USA | | | | Baltimore City | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN STATE, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | |
| Baltimore | | Sinal Hospital | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2712 Virginia Ave. | | 21215 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Owen | | Robinson | | Ruth | | Bowen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 212-36-8844 | | Ernest Pinkney | | 565 Greenwood Avenue | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Narcotism</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | M.D. | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE
SIGNED | | 9-13-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | Margarita A. Korell, M.D. | | ADDRESS | | 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 9/15/85 | | Mt. Calvary Cem. | | Anne Arundel Co. MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Wm. C. March F/H | | 1101 E. North Ave. | | SEP 10 1985 | | J. W. Arundel | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

000000



267049

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 4 3 4

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|------------------|--|--|--|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ORLANDO B. PINO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 17 85 | | 2b. HOUR
3:15A M |
| 3. SEX
MALE | 4. RACE
NERGO | 5. DATE OF BIRTH
MONTH DAY YEAR
5 17 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK, N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, Baltimore, Maryland 21218 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. COUNTY
MD. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JESUS PINO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDUVIGIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
072-12-2686 | | 17. INFORMANT
ADDRESS
ROSE PINO 301 SNOWHILL RD. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Upper GI Bleed</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Portal Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hepatic Cirrhosis</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
19a. DATE OF OPERATION | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>9/2/85</u> to <u>9/17/85</u> that <u>X</u> (we) last saw the deceased alive on <u>9/17/85</u> 19 <u>85</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>X</u> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Allen Solomon</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ALLEN SOLOMON</u> | | 22e. ADDRESS
<u>VAMC, Baltimore, Maryland 21218</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>BURIAL</u> | | 23b. DATE
<u>9-20-85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>GARRISON FOREST VET. CEM. OWINGS MILLS, MD.</u> | |
| 23d. LOCATION
(CITY OR TOWN, COUNTY, STATE) | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR
<u>LEROY O. DYETT 4600 LIBERTY HGTS AVE.</u> | | 25a. REGISTRAR'S SIGNATURE
<u>SEP 20 1985</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1, 2, and 3 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner or coroner must be notified.

CHINESE

253063

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (51))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25435
REG. NO. | |
|---|--|----------------------------------|--|--|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
William Player | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 9 2 19 85 | |
| 1. SEX Male | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 12 48 | | 6 AGE (IN YEARS LAST BIRTHDAY) 37 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 2 19 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3110 Woodland Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | | | | | | | 13b. COUNTY | |
| 13c. CITY OR TOWN Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 3100 Woodland Avenue | | | | | | | | | | 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wilkins Player | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bennie Williams | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 213-52-5218 | | | | 17. INFORMANT ADDRESS Wilkins Player 5135 Pembroke Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple gunshot wounds (unspecified weapon)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 11:05 PM 9-2- 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot. | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) porch | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3110 Woodland Ave., Balto. MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 9-3-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 6 1985 | | 25b. REGISTRAR'S SIGNATURE John Davidson Handell | | | |

20% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.



MADE IN U.S.A.

276102

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 5 4 3 6

REG. NO.

| | | | | | | | |
|---|--|--|--|---|------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Maude H Plews | | | 2a. DATE OF DEATH MONTH DAY YEAR
9 26 85 | | 2b. HOUR
8:51 P.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
4 12 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
David A. Flick CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MD HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNKNOWN | | 12b. KIND OF BUSINESS OR INDUSTRY
Homemaker | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MD | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
FRANK KRAMER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNE PRINCE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
216-01-5009D | |
| 17. INFORMANT ADDRESS
BARBARA J LUSBY 1 SAINT CHARLES PLACE | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
9 13 85 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE
Glen Burnie AA MD | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13 85 to 9/26 85 , that (I) (we) lost saw the deceased alive on 9/26 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | 22b. SIGNATURE
David A. Flick MD | | 22c. DEGREE
MD | | 22d. DATE SIGNED
9/26/85 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID A. FLICK MD | | 22f. ADDRESS
UNIV. OF MD HOSPITAL | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Sept. 26, 85 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Glen Burnie AA MD | | 24. FUNERAL DIRECTOR NAME
James S. Kirkley, Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 1 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | 25c. REGISTRAR'S NAME
Julia Davidson-Randall | | 25d. REGISTRAR'S ADDRESS
Julia Davidson-Randall | | 25e. REGISTRAR'S PHONE NO.
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

274066

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 4 3 7

| | | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|--------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
MICHAEL John PLUM | | | 7a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 24, 1985 | | | 7b. HOUR
09:35PM | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
April 13, 1985 | | 6 AGE (IN YEARS LAST BIRTHDAY)
IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
5 24 | | | | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hagerstown Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. CITY OR TOWN
Hagerstown | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
405 Cornell Avenue 21740 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John E. Lewis | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Aleesa J. Plum | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO. | |
| 17 INFORMANT
Aleesa J. Plum | | | ADDRESS
HAGERSTOWN Md. 21740 | | | 405 Cornell Ave. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN ISCHEMIA
DUE TO, OR AS A CONSEQUENCE OF (c) NEAR MISS SIDS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 minutes | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/22 , 19 85 , to 9/23 , 19 85 , that (I) (we) last saw the deceased alive on 9/23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
John J. The Closkey, M.D.
DEGREE | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/24/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John J. McCloskey, M.D. | | | | | | 22e. ADDRESS
JOHNS HOPKINS
601 N. WOLFE STREET
BALTIMORE, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Sept. 27, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Macedonia Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Greencastle Franklin Pa. | | | |
| 24 FUNERAL DIRECTOR
NAME
MINNICH FUNERAL HOME
415 E. Wilson Blvd., Hagerstown, Maryland 21740 | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 27 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon signature page 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STADDP



267051

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR. GIVE PAGES 3 AND 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM "P" 2, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 1- FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 5 4 3 8

| | | | | | | | | | |
|--|-------------------------|--|--|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) BERTHA PORTER | | | 2a. DATE OF DEATH
KNOWN ESTI-
MATED <input checked="" type="checkbox"/> 9-10-85 19 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6 24 1920 | 6. AGE (IN YEARS
LAST BIRTHDAY)
65 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE
PRONOUNCED
DEAD 9-10-85 19 | | | 2d. HOUR
5:20P |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3503 Reisterstown Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS
OR INDUSTRY
N/A | |
| 13a. STATE
Maryland | | 13b. CITY
N/A | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21215
3503 Reisterstown Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Taylor | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Daisey Taylor | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
George Taylor 4328 Park Hghts.Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stabwound of chest
(b) _____
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
7 9-10-85
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject found stabbed | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
CITY OR TOWN COUNTY STATE
3503 Reisterstown Rd. Baltimore, Maryland | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL
SIGNATURE
<i>Dennis F. Smyth</i> | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | DATE
SIGNED 9-11-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
9/14/85 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett & Son | | | ADDRESS
4600 Lib.Hghts.Ave. | | | 25a. DATE RECD. BY REGISTRAR
SEP 20 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John D. ...</i> | |

120000



259196

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 5 4 3 9

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MOREEN P PORTER | | | 2a. DATE OF DEATH
MONTH 9 DAY 11 YEAR 85 2b. HOUR 2:30 AM | | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH 6 DAY 26 YEAR 44 | 6. AGE (IN YEARS LAST BIRTHDAY)
41 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE
(CITY AND STATE)
Barbados | 7b. CITIZEN OF WHAT COUNTRY?
BWI | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITIAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| FATHER'S NAME
FIRST Keith MIDDLE Porter LAST Porter | | 15. MOTHER'S MAIDEN NAME
FIRST Carlotta MIDDLE Gibson LAST Gibson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-88-0123 | | 17. INFORMANT
ADDRESS
Michael Porter 5604 Ready Avenue | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

TERMINAL METASTATIC CANCERAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

OF COLON -

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
T. Emanuele, MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
9/11/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TULLIO EMANUELE | | 22e. ADDRESS | |

| | | | |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/18/85 | 23c. NAME OF CEMETERY OR CREMATORY
St. Michael's Row | 23d. LOCATION
CITY OR TOWN COUNTY STATE
St. Michaels Row, Barbados |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Avenue | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

2012

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

277095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 5 2 5 4 4 0 | | | | | | | | | |
| 1 - STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| FOR | | | | | | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | | | MONTH DAY YEAR 2b. HOUR | | | | | | | | | |
| Fletcher — Powell | | | | | | | | | | 9 26 85 8:22 PM | | | | | | | | | |
| 3 SEX | | | | | | | | | | 4 RACE | | | | | | | | | |
| male | | | | | | | | | | Black | | | | | | | | | |
| 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | | | | | | |
| MONTH DAY YEAR | | | | | | | | | | IF UNDER 1 YEAR IF UNDER 24 HRS | | | | | | | | | |
| 5 15 09 | | | | | | | | | | 76 YRS MONTHS DAYS HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| South Carolina | | | | | | | | | | U.S.A. | | | | | | | | | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | | | | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | Baltimore City MD. | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | |
| Baltimore | | | | | | | | | | University of Md. Hosp. | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| ? | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | |
| Maryland | | | | | | | | | | | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | |
| Baltimore | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | | | | | | | | | | | |
| 4741 Alhambra Ave. 21212 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | |
| Ruben — Powell | | | | | | | | | | Hannah — Goode | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| X | | | | | | | | | | 244-09-984 | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | |
| Bernice Powell | | | | | | | | | | same | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| IMMEDIATE CAUSE (a) cardiac arrest | | | | | | | | | | 30 minutes | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| chronic obstructive pulmonary disease; left hemicolectomy | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 8-2-85 | | | | | | | | | | bleeding from rectum | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | | | | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 21f. LOCATION | | | | | | | | | |
| | | | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| S. Barrows | | | | | | | | | | 9-26-85 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | |
| S. Barrows | | | | | | | | | | 22 S. Greene St., Baltimore MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | |
| BURIAL | | | | | | | | | | 10/2/85 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | | | | | | | | | |
| Baltimore | | | | | | | | | | Baltimore COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| W.C. March F/H Co. 1101 E. North Ave. | | | | | | | | | | OCT 1 1985 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Julia Davidson | | | | | | | | | | | | | | | | | | | |

2005002



2005002
COTTON

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

252106

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JACK POWELL | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 2, 1985 | | 2b. HOUR
M
10 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 17 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
50 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6439 Hartwait Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Assembler | | 12b. KIND OF BUSINESS OR INDUSTRY
General Motors |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Marion Powell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lessie M. Jarriel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-30-4647 | | 17. INFORMANT
ADDRESS
Mary E. Powell Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) malignant mesothelioma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Chi-Shiang Chen | | DEGREE | | 22c. DATE SIGNED
9-3-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHI-SHIANG CHEN | | 22e. ADDRESS
100 N. BROADWAY BALTIMORE, MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/5/1985 | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 | | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |



277034

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 4 4 2

| | | | | | | | | | |
|--|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JUANITA PRESCO | | | 2a. DATE OF DEATH MONTH 9 DAY 29 YEAR 85 | | | 7b. HOUR 2:34 AM | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH 3 DAY 24 YEAR 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Md City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 1808 Ashburton St +21216 | | | | 14. FATHER'S NAME DUNCAN | | 15. MOTHER'S MAIDEN NAME Maxwell Addie Griffin | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16a. SOCIAL SECURITY NO. 218-09-4122 | | | | 17. INFORMANT Mr. Frank Tibbs | | 17b. ADDRESS 1808 Ashburton St +21216 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) (Acute pulmonary edema)
DUE TO, OR AS A CONSEQUENCE OF (c) ASD
Approximate interval between onset and death 8 hrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
CARCINOMA COLON | | | | | | | | | |
| 19a. DATE OF OPERATION 9/21/85 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA COLON | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/29 , 19 85 , to 9/29 , 19 85 , that (I) (we) last saw the deceased alive on 9/29 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert Francisco MD DEGREE MD | | | | | | 22c. DATE SIGNED 9/29/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERTO FRANCISCO | | | | | | 22e. ADDRESS 750 ASHBURTON ST. BALTIMORE MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK BY) BURIAL | | | 23b. DATE 10-4-85 | | 23c. NAME OF CEMETERY OR CREMATORY BALTO. Nat. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD | | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ ADDRESS 2222 W. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1985 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

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10 MAY 5 07A 19
10 MAY 5 07A 19



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | DATE | | HOUR | |
| Samuel A Presti | | 9 1 85 | | 5:32 a.m. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| M | W | 7 15 1915 | | 70 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | St. Agnes Hospital, Caton Ave | | Inspector | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE | | 13b. COUNTY | |
| General Motors | | 4320 Highview Ave. 21229 | | Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| Steve Presti | | Catherine Crivelli | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 216-01-5020 | | Antoinette M. Presti | | 4320 Highview Ave. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest.</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <u>Right lower lobe pneumonia.</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) <u>Left pneumonia</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| <u>congestive heart failure</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost | | | | | |
| saw the deceased alive on <u>9/1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | |
| <u>Michelle Gordon MD</u> | | | | 9/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| <u>Michelle GORDON</u> | | | | <u>Caton Avenue (St. Agnes Hosp.)</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/5/85 | | Most Holy Redeemer | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | SEP 3 1985 | | <u>Jane Gordon-Hendall</u> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please immediately complete and return to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

140015

For: [illegible] [illegible] [illegible]

10/10/1967

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267123

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Elizabeth Jones Price | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11 SEPTEMBER 1985 | | 2b. HOUR
4 P.M. |
| 3 SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 21 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4637 Kernwood Ave. / 21212 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Thomas Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Olivia Hayman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | 17. INFORMANT ADDRESS
Constance A. Price, Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
DUE TO, OR AS A CONSEQUENCE OF
(b) CEREBRAL VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE
8 YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
CORONARY ARTERIAL DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 29 MAR 19 78 to 11 SEPT 19 85, that (I) (we) lost saw the deceased alive on 23 MARCH 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
J. Dixon Hills | | DEGREE
M.D. | | 22c. DATE SIGNED
12 Sept 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Dixon Hills, M.D. | | 22e. ADDRESS
3501 St. Paul St., Balto., Md. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/14/85 | 23c. NAME OF CEMETERY OR CREMATORY
Salem Methodist | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pocomoke City, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Norman F. Dennis, Snow Hill, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
SEP 17 1985 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
John R. Riddell | | |

BP

DHMH-16 50M 1/81
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274092

UNK.#85-71

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25445
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|------------------|---|---|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Lloyd | | MIDDLE
Priolieau | | LAST
(Prioleau) Jr. | | 2a. DATE KNOWN
OF DEATH
ESTIMATED
9-23 19 85 | | 2b. HOUR
M
1:50
a. M | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 5 66 | 6. AGE (IN YEARS)
LAST BIRTHDAY
19 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE
PRONOUNCED
DEAD
9-23 19 85 | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
800 blk. N. Chapel Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1516 N. Durham St. 21213 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lloyd Priolieau, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Branch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
220-80-4714 | | 17. INFORMANT
ADDRESS
Lloyd Priolieau, Sr. 2323 Ashland Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot Wound of Head (unspecified)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1:45XX 9-23 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject was shot | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
800 blk. N. Chapel St., Baltimore, Maryland | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER | | DATE SIGNED
9-23-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL
(1) BURIAL | | 23b. DATE
9/30/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | | | ADDRESS
1101 E North Avenue | | 25a. DATE REC'D BY REGISTRAR
SEP 27 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

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DHMH - 17
(VR A15 ME (1))

9481-10700 2008

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268131

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | |
|--|---|--|---|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
BURNIE E. PRIVETTE | | | 2a DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 19, 1985 | | 2b HOUR
09:00PM |
| 3 SEX
Male | 4 RACE
Black | 5 DATE OF BIRTH
MONTH DAY YEAR
2 13 45 | | 6 AGE (IN YEARS LAST BIRTHDAY)
40 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
N.C. | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE
Md. | | | 13b CITY OR TOWN
Woodlawn | 13c STREET ADDRESS / ZIP CODE
3504 Melody Lane 21207 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Ed Privette | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| 16 WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO.
Vietnam 217-40-4171 | | 17 INFORMANT
Hattie Privette | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | DUE TO, OR AS A CONSEQUENCE OF
(b) RENAL FAILURE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 MINUTE | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF
(c) ACUTE MYELOFIBROSIS | | 1 WEEK | |
| | | | | 1 MONTH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
HYPOALBUMINEMIA | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 9/5 , 19 85 , to 9/19 , 19 85 , that (I) (we) last saw the deceased alive on 9/19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
H. Youssoufian | | DEGREE
MD | | 22c DATE SIGNED
9/19/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
HABOP YOUSSEOUFIAN | | 22e ADDRESS
JOHNS HOPKINS HOSPITAL, BALTIMORE, MD | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b DATE
9/24/85 | 23c NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. | |
| 24 FUNERAL DIRECTOR
NAME
Wm C March F/h, Inc West | | ADDRESS
4300 Wabash Ave | | 25a DATE REC'D. BY REGISTRAR
SEP 23 1985 | |
| | | | | 25b REGISTRAR'S SIGNATURE
<i>John Harrison Henderson</i> | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. FLEETON ST., BALTIMORE, MARYLAND 21201

PRIVETTE, BURNIE E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be issued within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene for statistical, criminal, or removal.

IMPORTANT: If item 21 is marked as fatal, it states any injury, or other traumatic event, the medical examiner may be required to conduct an autopsy.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

101 403



GENERAL SERVICE
UNITED STATES
NAVY
ST. JOSEPH, MO.

270010

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
(Deazimerie) Hilda Pryor | | 2a DATE OF DEATH
MONTH DAY YEAR
September 23, 1985 | | 2b HOUR
M
M | |
| 3 SEX
Female | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
2 3 22 | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
63 YRS | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2022 East Biddle Street | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a STATE
Maryland | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | |
| 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
2022 E Biddle St. 21213 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
James Pryor | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Bundy | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | 16b SOCIAL SECURITY NO.
217-14-6853 | | 17 INFORMANT ADDRESS
Sarah Wilson 2022 E. Biddle Street | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (b) diabetes mellitus
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
chronic obstructive pulmonary disease | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from May 1976 to Sept 1985 that (I) (we) last saw the deceased alive on 9/11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) show the body after death . | | | | | |
| 22b SIGNATURE
Robert T Smith MD | | DEGREE | | 22c DATE SIGNED
9/24/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Robert T Smith | | 22e ADDRESS
1000 Eager Street Balto | | | |
| 23a BURIAL, CREMATION, REMOVAL
BURIAL | | 23b DATE
9/26/85 | | 23c NAME OF CEMETERY OR CREMATORY
Eastview Mem. Pk. | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Avenue | | 25a DATE REC'D. BY REGISTRAR
SEP 25 1985 | | | |
| 25b REGISTRAR'S SIGNATURE
Sarah Wilson | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES PUMPHREY, JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-16-85 | | | 2b. HOUR
4:32 M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 29 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Cemetery | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS - ZIP CODE
3547 6th Street 21225 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES PUMPHREY SR. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SADIE JACKSON | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCE?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
011-140-499 | | | 17. INFORMANT
Georgiana Pumphrey | | | ADDRESS Balto. Md. 31225
3547 6th Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction.
DUE TO, OR AS A CONSEQUENCE OF
(b) INTRACTABLE VENTRICULAR ARRHYTHMIA.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
CHRONIC OBSTRUCTIVE PULM. DISEASE | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Michael Knorr | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
7-16-80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KAZAK MICHAEL | | | | | 22e. ADDRESS
3001 So. HANOVER ST. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9-19-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. MD. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McCully Funeral Home Inc. Balto. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 20 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Burdick | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP. _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Proper final disposal must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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RECEIVED
JUL 10 1964
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.



Department of Agriculture

U.S. DEPT. OF AGRICULTURE

Office of the Director of the
Bureau of Plant Industry

Washington, D.C.

Attention: Mr. [Name]

Enclosed for you are [Number] copies of [Document Name]

which you will find of interest.

Very truly yours,
[Signature]

Director, Bureau of Plant Industry

Enclosed for you are [Number] copies of [Document Name]
which you will find of interest.

52-131



281015

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Edward L. Putzel</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>09 29 85</i> | | | 2b. HOUR
MIN.
<i>11 30 AM</i> | | | | |
| 1. SEX
<i>M</i> MALE | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>01 15 07</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
<i>78</i> | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE CITY</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Sinai Hospital, Baltimore</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Lawyer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>AT LAW</i> | | |
| 13a. STATE
<i>MD</i> | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>BALTO.</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>6404 Laurel Drive #21207</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Lewis Putzel</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Birdie Rosenberg</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>214-38-7584</i> | | 17. INFORMANT
<i>MRS. JANITH BLOUT PUTZEL</i>
<i>Baltimore, Maryland</i> | | | | 21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Pulmonary Embolism</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>SIV MI E CHF / SEPSIS</i> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>5 min</i>
<i>15 min</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>HTN; CVA; Sepsis</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>01/15</i> , 19 <i>05</i> , to <i>09/29</i> , 19 <i>85</i> , that (I) (we) last
saw the deceased alive on <i>09/29</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Edward L. Putzel</i>
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
<i>9/29/85</i> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Friedrich J. Van Mar</i> | | | | | | 22e. ADDRESS
<i>Greenberg at Belvedere / Sinai Hospital</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>BURIAL</i> | | | 23b. DATE
<i>OCT. 2, 1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>HAR SINAI</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>OWINGS MILLS BALTO. MD</i> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>SOL LEVINSON & BROS., INC.</i>
<i>6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>OCT 4 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 4 5 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROSIE QUICKLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 16, 1985 | | 2b. HOUR
M
M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
4 14 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
80 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1707 N. MOUNT STREET | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Jackson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Zora Crumwell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-16-7970 | | 17. INFORMANT
ADDRESS
Mary Walker 4509 Dunland Road | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), or (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT HOME | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from 9/14/85 to 9/18/85
saw the deceased alive on 9/14/85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
(above) (I saw) (did not see the body after death). | | | | | |
| 22b. SIGNATURE
Ismae Berger | | 22c. ADDRESS
2435 West Baltimore Ave | | 22d. DATE SIGNED
9/18/85 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Ismae Berger | | 22f. ADDRESS
2435 West Baltimore Ave | | 22g. DATE REC'D. BY REGISTRAR
SEP 19 1985 | |

| | | | |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/19/85 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Nat'l Cen. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C March F/H Inc. 1101 E North Avenue | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | |
| 25b. REGISTRAR'S SIGNATURE
ina Davidson-Rendell | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 must be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON LEECH

WILEY



880-035

269046

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|---|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Alfred William Quillen | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 21 85 | | | 2b. HOUR
5:05 PM | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASION | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 28 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MINS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY
RENTAL | | |
| 13a. STATE
MD | | | 13b. COUNTY
XXXXXX | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> XXX | | 13e. STREET ADDRESS / ZIP CODE
7017 MARIETTA AVE 21234 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Albert Quillen | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sally Lewis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-05-8020A | | 17. INFORMANT ADDRESS
Susan Q. Irons, 11 Durness Ct., 21236 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Ruptured abdominal aortic aneurysm.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
09. 21. 85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ruptured Abdominal Aortic Aneurysm | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 09-18-1985 to 09-21-1985, that I (we) last saw the deceased alive on 09-21-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (do) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
CHUNG CHU Ng MD. | | | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHUNG CHU Ng MD. | | | | 22e. ADDRESS
5808 Bel air Road, Balto. Md 21206. | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Sept. 25, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Balto., Md. 21214 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

269160

FOR
1- STATE REGISTRAR Leonard Joseph QuinnSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Leonard J Quinn | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 9 85 | | 2b. HOUR
2:50 M | |
| 3. SEX
M | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
07 16 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DLA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ. of Maryland Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Farmer | | |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE MD 13c. CITY OR TOWN Kent | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Box 162A 20825 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel J. Quinn | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary C. Cornelius | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-24-1165 | | 17. INFORMANT
ADDRESS
Chas | | |
| 18. CAUSE OF DEATH Enter only one cause per line for 18a, 18b, and 18c.
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic Shock
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction Pericard.
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Artery Disease | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Coronary Artery Bypass | | | | | | |
| 19a. DATE OF OPERATION
9 Sept '85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CAD | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
F. Clark Sauls | | DEGREE:
MD | | 22c. DATE SIGNED
9 Sept '85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F. Clark Sauls | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
9-14-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Schreewsbury Cem | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Kennedyville Kent Md | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Fellows Funeral Homes Millington, Md. | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
SEP 18 1985 | | | | |

031035



~~CONFIDENTIAL~~

382003



263125

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 4 5 5
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) PETRONELA | | FIRST RAKOW | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR
09 15 85 | | 7b. HOUR
1 28 AM | |
| 3 SEX
FEMALE | | 4 RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
July 12 1901 | | 6 AGE (IN YEARS LAST BIRTHDAY)
84 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ukraine | | 7b. CITIZEN OF WHAT COUNTRY?
Ukraine | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |

| | | | | | | | | | |
|---|--|------------------------------|--|---------------------------------|--|---|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
--- | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3045 N. St. John's Lane 21043 | |
|---|--|------------------------------|--|---------------------------------|--|---|--|--|--|

| | | | |
|--|--|---|--|
| 14. FATHER'S NAME
FIRST Unknown MIDDLE Hrybovska LAST | | 15. MOTHER'S MAIDEN NAME
FIRST Unknown MIDDLE Unknown LAST | |
|--|--|---|--|

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
194 26 6412 | | 17. INFORMANT
Osyg Zinkewych | | ADDRESS
3045 N. St. John's Lane 21043 | |
|---|--|---|--|--|--|---|--|

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Supraventricular Tachycardia
DUE TO, OR AS A CONSEQUENCE OF
(c) --- | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
15 minutes
2 weeks | |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **---**

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from **8/21**, 19 **85**, to **9/15**, 19 **85**, that (I) (we) last saw the deceased alive on **9/15/85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | | | | | |
|---|--|---------------------|--|--|--|------------------------------------|--|
| 22b. SIGNATURE
Christine J. Bell-Lafferme | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/15/85 | |
|---|--|---------------------|--|--|--|------------------------------------|--|

| | | | |
|--|--|---|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHRISTINE J. BELL-LAFFERME | | 22e. ADDRESS
MERCY HOSPITAL 301 ST PAULS PLACE BALTO MD | |
|--|--|---|--|

| | | | | | | | |
|---|--|---------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Sept 17 '85 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Michael Ukr Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
|---|--|---------------------------------|--|---|--|--|--|

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler, Inc. | | ADDRESS
21231 1901 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
SEP 18 1985 | | 25b. REGISTRAR'S SIGNATURE
--- | |
|---|--|---|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, then medical attention should be noted at once.

MEDICAL CERTIFICATION

BP

531630



LIBRARY OF THE U.S. DEPARTMENT OF AGRICULTURE



249027

Ellis A. Rawls

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

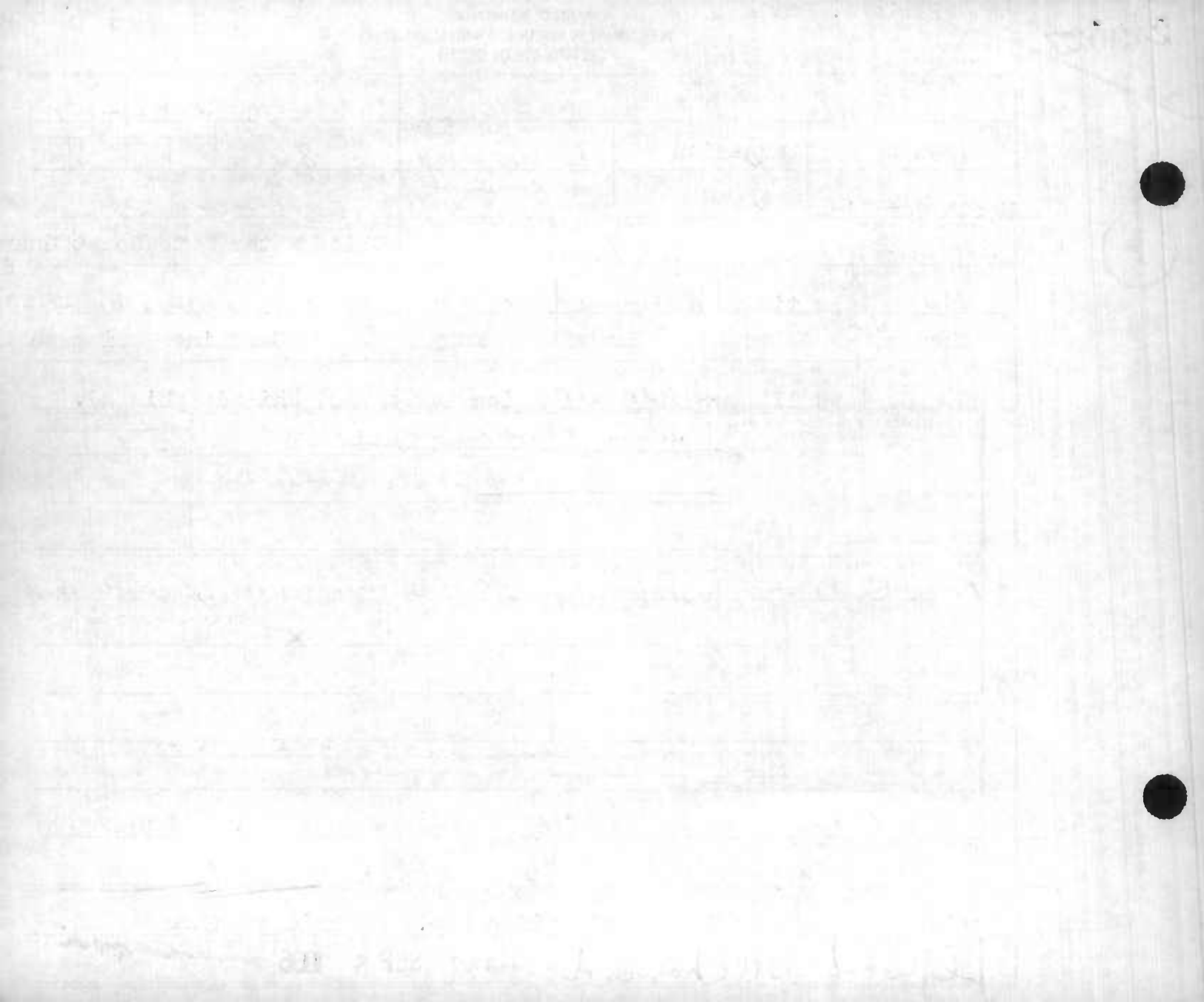
| | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ellis A Rawls | | | 2a. DATE OF DEATH
MONTH 9 DAY 2 YEAR 85 | | | 2b. HOUR
2:30 PM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 10 DAY 15 YEAR 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wyman Park Health System | | | | 12a. USUAL OCCUPATION
(IF DECEASED WAS NOT WORKING LIST YOUR INDUSTRY)
Chief Motor Mate Coast Guard | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7524 Philadelphia Rd 21237 | |
| 14. FATHER'S NAME
FIRST Charles LAST Allen | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Caroline LAST Simpson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
ADDRESS
Alice Rawls 7524 Philadelphia Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) acute respiratory failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) Myocardial infarction
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Metastatic Prostate Ca, Hypercalcemia, COPD, atherosclerosis, cigarette abuse | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-30 , 19 85 , to 9-2 , 19 85 that (I) (we) last saw the deceased alive on 9-2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Scott Touger DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
9-2-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Scott Touger | | | | 22e. ADDRESS
Wyman Park Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cem. | | 23d. LOCATION
CITY OR TOWN Elkridge COUNTY Howard STATE Md. | | | |
| 24. FUNERAL DIRECTOR
Jeffrey ADDRESS 1211 Chesaca Ave, 21037 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 3 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



259076

Items 18-22a 12/9/85 mtb F#610

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 4 5 7

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|----------------|--|--|--|-------------------|--|--|--|--------------------------------------|--|--|--|--------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MARY | | MIDDLE E. | | LAST RAY | | 2a. DATE KNOWN OF DEATH | | MONTH 9 | | DAY 3 | | YEAR 1985 | | 2b. HOUR | |
| 3 SEX F | | 4 RACE W | | 5. DATE OF BIRTH
MONTH DAY YEAR | | APRIL 10 1929 | | 6. AGE (IN YEARS)
LAST BIRTHDAY | | 56 YRS. | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | Baltimore City | | MD. | | 12. HOUR 12:40 A.M. | |
| 10. CITY OR TOWN OF DEATH | | Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | Church Hospital | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | EXAMINER | | 12b. KIND OF BUSINESS OR INDUSTRY | | CLOTHING | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 21205 | | 2724 JEFFERSON ST. | | | |
| 14. FATHER'S NAME | | FIRST CAROL E. | | MIDDLE JOHNSON | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST AGNES M. | | MIDDLE ROACH | | LAST | | 21205 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | NO | | 16b. SOCIAL SECURITY NO. | | 216-24-1816 | | 17. INFORMANT | | ADDRESS | | Mrs. Agnes M. Jacobs - 2724 Jefferson | | 21205 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Mixed Drug overdose</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 9/3 1985 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Ingested drug | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2724 E. Jefferson St. Balto., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | DATE SIGNED 9-3-85 | | | | | | | | | | | | | |
| Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | | | SEPT. 6 1985 | | | | | | | | Ellicott City Howard Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| HARTLEY Miller | | | | 2332 JEFFERSON ST | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. THIS CERTIFICATE IS VALID FOR 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS CERTIFICATE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP 1304
DHMH - 17
(VR A15 ME (5))

FILED OCT 10 1902

RECEIVED
OCT 10 1902

Handwritten notes and signatures, including "X" and "A", are visible on the lined paper.

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#1, Film G608 10/3/85 ra

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 4 5 8

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAA' (TYPE OR PRINT) aka Elizabethh Clark
<i>MATTIE</i> | | LAST
<i>REED</i> Reed | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>SEPT. 27 1988</i> | | 2b. HOUR
<i>8:05 P.M.</i> | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
1 23 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Texas | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
733 Newington Avenue 1st Fl | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Lemmie Clark | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Bertha Lee Scott | | 16. STREET ADDRESS / ZIP CODE
733 Newington Avenue 1st Fl 21217 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Bertha Lee Robinson 4807 Colonial Ave | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CANCER OF RT KIDNEY WITH INVOLVEMENT OF ADRENALS AND PLEURA</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>AUG. 16</i> 19 <i>88</i> to <i>SEPT. 27</i> 19 <i>88</i> that (I) (we) lost saw the deceased alive on <i>SEPT. 27</i> 19 <i>88</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>J.M. Jaramoy</i> | | DEGREE
<i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>L.M. Jaramoy</i> | | 22e. ADDRESS
<i>102 N. BROADWAY, BALTO. MD. 21201</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
10/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Church Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Dallas, Texas | |
| 24. FUNERAL DIRECTOR
Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Sander-Rodriguez</i> | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper's Pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

101275

REBIL NO 100 200

WILSON



275095

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|--|---|-----------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FLORENCE E. REES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 25, 1985 | | 2b. HOUR
9:00 A M | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 6, 1895 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
90 | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3111 N. Charles Street Apt. 1B | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 13a. STREET ADDRESS / ZIP CODE
3111 N. Charles St. Apt. 1B | | | | |
| 13b. COUNTY
Maryland | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
011-28-5459 | | 17 INFORMANT
ADDRESS
Mr. Arthur Drager 5 Light Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrhythmia.
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute myocardial infarction.
DUE TO, OR AS A CONSEQUENCE OF
(c) 1 day. | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Senile Dementia of the Alchেমiers Type; Rectal carcinoma. | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) [this hospital] attended the deceased from May 6 , 19 82 , to Sept. 25 , 19 85 , that (I) [we] last
saw the deceased alive on Aug. 21 , 19 85 , and that in (my) [our] opinion death occurred on the date and hour and from the causes stated
above. (I) [we] did [did not] view the body after death. | | | | | | |
| 22b. SIGNATURE
George T. Tyler, MD | | DEGREE
MD | | 22c. DATE SIGNED
Sept. 26, 1985 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George T. Tyler, MD. | | 22e. ADDRESS
600 Light Street Baltimore, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Sept. 27, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cem. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Barton, Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | | 25b. REGISTRAR'S SIGNATURE
Carroll Davidson | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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Film G608 item 16b

1- STATE 10/24/85 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 4 6 0

| | | | | | | | |
|---|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JOSEPHINE REEVES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/25/85 | | 2b. HOUR
9:55 AM | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
03/24/85 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Kitchen Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Bakery | |
| 13a. STATE
Md | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Hampstead | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harris | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Martin | | 13e. STREET ADDRESS / ZIP CODE
1634 St. Paul Street 21074 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-07-6528 | | 17. INFORMANT
ADDRESS
Jean Bellusci | | 17. INFORMANT
ADDRESS
SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-6- 19 85 to 9-25- 19 85 , that (I) (we) last saw the deceased alive on 9-25- 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Matthew | | DEGREE | | 22c. DATE SIGNED
9-25-85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Mathew | |
| 22e. ADDRESS
Lutheran Hospital - 730 Ashburton St Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
09/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn, Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Burgee-Henss Funeral Home, 3631 Falls Road 21211 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



260035

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT) CATHERINE M. REICHART | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 11 1985 | | 2b. HOUR 5.34 PM |
| 3 SEX F | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR JULY 26 1918 | 6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | |
| 10 CITY OR TOWN OF DEATH BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY 13c. CITY OR TOWN BALTO. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS + ZIP CODE 3202 FAIT AVE. 21224 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST HERMAN MARTIN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE Ricklin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. 213-18-6418 | 17 INFORMANT ADDRESS HERMAN REICHARDT 8045 WYNBROOK RD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CIRCULATORY FAILURE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) SUSPECTED SEPSIS | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) GASTROINTESTINAL BLEEDING | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 6, 1985, to SEPTEMBER 11, 1985, that (I) (we) last saw the deceased alive on SEPTEMBER 11, 1985, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] MD | | DEGREE MD | | 22c. DATE SIGNED 21231 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID MADOFF M.D. | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY BALTI, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK IF) BURIAL | 23b. DATE 9-14-85 | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM. | 23d. LOCATION CITY OR TOWN COUNTY STATE A.A. CO. MD. | | |
| 24 FUNERAL DIRECTOR NAME HOFFMANN-SKARDA ADDRESS 3218 HUDSON ST. | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1985 | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and signed by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is designated to do so.

2500032



VIDE

2022 COLLEGE

VIDEO

WINTER

10

263438

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|--|---------------------------|---|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
JOSEPH CHRISTOPHER REICHERT, SR. | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 16 85 | | | 2b HOUR
7:10 PM | | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
MARCH 19, 1928 | | 6 AGE (IN YEARS LAST BIRTHDAY)
56 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VETERANS ADMINISTRATION MEDICAL CENTER | | | | 12a USUAL OCCUPATION
(TYPE OF WORK OR BUSINESS)
ROUTE MGR. | | 12b KIND OF BUSINESS OR INDUSTRY
BEVERAGE | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
MARYLAND | | | 13b COUNTY
HARFORD | | 13c CITY OR TOWN
JOPPA | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
CHARLES REICHERT | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
WILMUTH PHOEBUS | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | | |
| 16b SOCIAL SECURITY NO.
W.W. II 220205009 | | | 17 INFORMANT ADDRESS
CAROLYN KASPRZAK 980 SANDALWOOD RD 21222
VAMC 3900 LOCH RAVEN BLVD BALTO, MD 21218 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for a), b), and c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bladder Cancer</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) | | | | | | | | | | |
| 19a DATE OF OPERATION
— | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22 I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 10</u> 19 <u>85</u> to <u>SEPTEMBER 16</u> 19 <u>85</u> , that <u>XX</u> (we) saw the deceased on <u>SEPTEMBER 16</u> 19 <u>85</u> , and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (We <u>XX</u> did not see the body after death.) | | | | | | | | | | |
| 22b SIGNATURE
<i>[Signature]</i> | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED
9/17/85 | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
JASKULSKY MD | | | 22e ADDRESS
3900 LOCH RAVEN BLVD BALTO, MD 21218 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b DATE
SEPT. 19, '85 | | | 23c NAME OF CEMETERY OR CREMATORY
MD. VETERANS CEMETERY | | | 23d LOCATION
CITY OR TOWN COUNTY STATE
GARRISON FORREST, MD | |
| 24 FUNERAL DIRECTOR
NAME
WILLIAM E. JOHNSON | | | | | | 25a DATE REC'D. BY REGISTRAR
SEP 18 1985 | | 25b REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of body.

20% COTTON FIBER

MADE IN U.S.A.



269113

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|--|---|---|---|--|--|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Rodney Richard Reilly | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 20 85 | | 2b. HOUR
5:08 pm | | | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 3 1921 | | 6 AGE (IN YEARS LAST BIRTHDAY)
64 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Iowa | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
17 Hamill Road 21210 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Economist | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY ----- 13c. CITY OR TOWN Baltimore | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
17 Hamill Road 21210 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph ----- Reilly | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Grace Lynch | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17 INFORMANT
ADDRESS
Britt Marie Reilly (same as 13e.) | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal Cancer with neck node metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>12 months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Kathy J. Helzlouer</u> MD | | | | | | DEGREE | | 22c. DATE SIGNED
9/21/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kathy Helzlouer, MD | | | | | | 22e. ADDRESS
600 N. Wolfe Street Baltimore, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
9/21/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Centery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | |
| 24 FUNERAL DIRECTOR
NAME
Walter Brooks Bradley Inc. Balto., Md. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
SEP 24 1985 | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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275019

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 5 2 5 4 6 4

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|---------------------------|---|--|---|---|--------------------------------|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ruth A. Resh | | | 2a. DATE OF DEATH
MONTH DAY YEAR 09/28/85 | | 2b. HOUR
452 AM | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR Sept. 21, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 72 HRS.
HOURS MIN. | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ. of Maryland Hospital | | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
Chiropractor | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Practice | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BY DATE OF ADMISSION)
13a. STATE Maryland | | | 13b. CITY Baltimore | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS / ZIP CODE
238 N. Eutaw St. 21201 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
August Tischler | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Matilda Teske | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
207-09-0823 | | | 17. INFORMANT (Brother) ADDRESS
58 Carey WilkesBarre, 18702 Pa. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopul Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Unknown
DUE TO, OR AS A CONSEQUENCE OF
(c) Unknown | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Sepsis, ARDS | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/27/85 19 to 9/28/85 19, that (I) (we) last saw the deceased alive on 9/27/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Stephen F Knox | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 17c. DATE SIGNED
9/28/85 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN F KNOX | | | | | | 22e. ADDRESS
401 MD Dept of Medicine | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
10/1/85 | | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hanover Twsp. Luzerne Pa. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
E. Barnes | | | | | | ADDRESS
21018 Benson, Md. | | | 25. DATE RECD. BY REGISTRAR
SEP 30 1985 | | | 26. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is complete. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

372013



CHIEF MEDICAL OFFICER

44413 101103 2000

James Michael Services, Inc.
2000
101103
44413

261015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHERINE REULING | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 8 85 | | 2b. HOUR
4:40 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 15 1914 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MEDICAL CENTER | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALBERT W. REULING | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CATHERINE PFIEFFER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-22-1979 | | 17. INFORMANT
ADDRESS
Earl & Mary Reuling 1630 Worthington Heights 21030 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Brain tumor</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>60 Minutes</u>
Yeniss. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a. DATE OF OPERATION
8.20.85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Brain tumor | | 20a. AUTOPSY
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8.15.85</u> , 19 <u>85</u> , to <u>9.8</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9.8</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
MD | | 22c. DATE SIGNED
9.8.85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD CHEN | | 22e. ADDRESS
600 N. WOLFE ST.
BALTIMORE, MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9-11-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Maryland | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE | | ADDRESS
21229 | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Left

Right

266084

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DONNA G REUWER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09 16 1985 | | 2b. HOUR
7:59PM
M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
4 6 63 | | 6. AGE (IN YEARS LAST BIRTHDAY)
22 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Government |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY A.A. 13c. CITY OR TOWN Severn | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William E. Beam | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah L. Cooper | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-86-6361 | | 17. INFORMANT
ADDRESS
Severn, Maryland 21144
Mark E. Reuwer 1416 Washington Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>FUNGAL SEPTICEMIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>SYSTEMIC LUPUS ERYTHEMATOSUS</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 MINUTES</u>
<u>4 DAYS</u>
<u>2 YEARS</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CECAL PERFORATION AND REPAIR, RENAL FAILURE, COMA</u> | | | | | |
| 19a. DATE OF OPERATION
8-13-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CECAL PERFORATION AND BLEEDING | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>8-13</u> 19 <u>85</u> to <u>9-16</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>9-16</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Kenneth J. Holroyd | | DEGREE
MD | | 22c. DATE SIGNED
9-16-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KENNETH J. HOLROYD | | 22e. ADDRESS
THE JOHNS HOPKINS HOSPITAL
BALTIMORE MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Raymond C. Fink Glen Burnie, Md. 21061 | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
SEP 18 1985 Julia Gordon-Rodell | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low registrar both certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the registrar, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

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263139

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHERINE B. REYNOLDS | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 17 1985 | | 2b. HOUR
8:30 P.M. | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
5 28 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF APPLICABLE)
UNION MEMORIAL HOSPITAL 21218 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
-- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elmer Burton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
M. Duvall | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-18-7495 | | 17. INFORMANT ADDRESS
Thomas Reynolds 15 Tenbury Rd. 21093 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Renal failure
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12 , 19 85 , to 9/17 , 19 85 , that (I) (we) lost
saw the deceased alive on 9/17 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Betsy A. Fay DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
9/17/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BETSY A. FAY | | 22e. ADDRESS
M.D. UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9/20/85 | 23c. NAME OF CEMETERY OR CREMATORY
New Catharal Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 18 1985 REGISTRAR'S SIGNATURE
<i>John Burton</i> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP
DHMH - 17
(VR A15 ME (5))
1- FOR
STATE
REGISTRAR
 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25468

| | | | | | | | | | |
|--|-------------------------|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James L. Rhoney | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
9 3 1985 | | | 2b. HOUR
10A | | | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
9 6 1940 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
44 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 3 1985 | | | 7d. HOUR
10A |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4986 Denmore Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4986 Denmore Avenue 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alonzo Rhoney | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lottie M. Chambers | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Ernest Rhoney 4986 Denmore Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic alcoholism with fatty liver
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 9/3/85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | ADDRESS
111 Penn St. Balto. MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H Inc. 4300 Wabash Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 6 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 8 5 2 5 4 6 9 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Lonnice | | | | | | Richardson Jr | | 9 01 85 | | 12:38am M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Male | | Black | | 09 12 24 | | 60 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| FLORENCE S. C. | | USA | | | | City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Sinai Hospital | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | | | | | BALTIMORE | | XX | | 2434 E. LAFAYETTE AVE. 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| LONNIE RICHARDSON SR. | | | | | | INEZ HORTON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| YES | | 247-20-0787 | | MARY C. RICHARDSON 2434 E. LAFAYETTE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of Colon</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (if this hospital) attended the deceased from <u>8/25</u> , 19 <u>85</u> , to <u>9/1</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>9/1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | 22c. DATE SIGNED | | | |
| <u>N. Brooks-Reddix MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | <u>9/1/85</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Natalie Brooks-Reddix MD | | Sinai Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 9/6/85 | | GARRISON FOREST | | | | OWINGS MILLS MD | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| WM. C. MARCH F/H 1101 E. NORTH AVENUE | | SEP 5 1985 | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | |
|--|--|--|--|---|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MOSES A. RICHESON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 2 85 | | 2b. HOUR
1:07p_M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 30, 1938 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
47 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS | | 8. IF UNDER 24 HRS.
HOURS MIN.
1:07p_M | | |
| 9a. BIRTHPLACE
STATE OR FOREIGN COUNTRY
Virginia | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC BALTIMORE, MARYLAND 21218 | | 12. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Messenger | | |
| 13a. COUNTY
District of Columbia | | 13b. CITY OR TOWN
Washington | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Moses H. Richeson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Jennie Eubanks | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | |
| 16b. SOCIAL SECURITY NO.
224 48 7663 | | 17. INFORMANT
ADDRESS
Doretha Richeson-wife-324 35th St., N.E. | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Coagulopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) Cirrhosis

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

~hrs
at least 6 days
unknown
yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (we) hospital attended the deceased from <u>August 22, 1985</u> to <u>September 2, 1985</u> that (we) last
saw the deceased alive on <u>September 2, 1985</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated
above, (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Sandra Marshall MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>9/2/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Sandra Marshall MD</u> | | | | 22e. ADDRESS
<u>Loch Raven VA Medical Center</u> | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Sept. 1, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Chestnut Grove Baptist Cemetery, Monroe, Va | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Stewart Funeral Home-4001 Benning Road, N.E. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John T. Stewart, III</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
emailed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

D.

321143



МНОГО

МИЛЛИОН

РАБОТЫ ИЛИТОС 3003

256061

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Helen W. Ridgeway | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 8 85 | | | 2b. HOUR
P.M.
2:00 | |
| 3. SEX
FEMALE | | 4. RACE
W. | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 3 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
M.D. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
2211 W ROGERS AVE ~21209 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
William F. Whiting | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma A. Jaunpers. | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
220-443020 | | 17. INFORMANT
WESLEY HOME | | 2211 W. ROGERS AVE | | 21209 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCT</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CORONARY ARTERY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Years.</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> 19 <u>80</u> , to <u>9/8</u> 19 <u>85</u> , that (II) (we) last saw the deceased alive on <u>8/22</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert E. Roby M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9-9-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT E. ROBY | | 22e. ADDRESS
8817 Belair Rd. 21236 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | 23b. DATE
9/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld | | | | ADDRESS
6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Sonia Davidson-Randall | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon pages: Pages 1 and 2 should be filed in the 72 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP



MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]
DATE: [Illegible]
BY: [Illegible]

[Illegible text block containing several paragraphs of a memorandum.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

274114

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 5 2 5 4 7 2

| | | | | | | | | | | | |
|--|--|--|---|--|--------------------------------|--|---|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Phillip Riley | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 25 1985 | | | 2b HOUR
M | | | | | |
| 3 SEX
male | | 4 RACE
black | | 5 DATE OF BIRTH
MONTH DAY YEAR
4 13 99 | | 6 AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | 6a IF UNDER 1 YEAR
MONTHS DAYS | | 6b IF UNDER 24 HRS.
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b CITIZEN OF WHAT COUNTRY?
U S A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
740 Poplar Grove Street | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemp | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
740 Poplar Grove Street apt 1 21214 K | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Unk | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unk | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-03-7151 | | 17 INFORMANT
Joseph Armstrong 6110 Meadow Avenue | | | | ADDRESS | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>COLON CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<u>CMLN</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 84</u> to <u>Sept 19 85</u> , that (I) (we) last saw the deceased alive on <u>Sept 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Marc Dan</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
9/27/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>MARC DAN</u> | | | | 22e. ADDRESS
<u>9057 BALZ MAR RYE C MD 2104</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown Md | | | | | |
| 24 FUNERAL DIRECTOR
NAME
William C. March F/H Inc West 4300 Wabash Ave | | | | | | 25a. DATE REC'D BY REGISTRAR
SEP 27 1985 | | 25b. SIGNATURE OF REGISTRAR
<u>John Davidson</u> | | | |

BP

PRINTS



WILLIAM
J. BROWN
JAN 10 1900

1885

252143

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR VIRGINIA MADDOX RILEY

| | | | | | | | | | | |
|--|--|---|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Virginia Maddox Riley</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9 2 85</i> | | | 2b. HOUR
<i>5:30</i>
A M | | | | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>August 29, 1893</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS
<i>92</i> | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Balto City</i> MD. | | | | |
| 10 CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St. Agnes</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | |
| 13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Carroll</i> | | 13c. CITY OR TOWN
<i>Westminster</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>1221 New Windsor Pike 21157</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George William Maddox</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Lucy Virginia Lancaster</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>212-10-2975D</i> | | 17 INFORMANT
<i>Carol Baker</i> | | ADDRESS
<i>4501 Old Frederick Road Baltimore, Md. 21229</i> | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

Renal insufficiency, myocardial infarction

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

9.2.85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Baltimore, Md.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial

23b. DATE

9/4/85

23c. NAME OF CEMETERY OR CREMATORY

Baltimore National

23d. LOCATION

Baltimore

COUNTY

Md.

24. FUNERAL DIRECTOR

*Leroy M. & Russell C. Witzke Funeral Homes P.A.
1630 Edmondson Avenue, Catonsville, Md. 21228*

25a. DATE REC'D. BY REGISTRAR

SEP 5 1985

25b. REGISTRAR'S SIGNATURE

[Signature]

MEDICAL CERTIFICATION

CRISIS

(7)

273055

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical investigation is required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Howard RANDOLPH RINGGOLD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 24 85 | | | 2b. HOUR
5 14 P M | |
| 3. SEX
M | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 02 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSP OF BALT | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE CITY OR TOWN
MD BALT | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
21217
2136 N FULTON AVE. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William B. Ringgold | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena Brown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-056000 | | 17. INFORMANT
ADDRESS
Lena Cooper 2136 N. Fulton Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>ASCVD, SIP INFERIOR MYOCARDIAL INFARCT, HYPERTENSION</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/23 4³⁰ 19 85</u> to <u>9/24 2³⁰ 19 85</u> , that (I) (we) last saw the deceased alive on <u>22³⁰ 9/24 19 85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>VORPERMAN</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VORPERMAN VICKOW | | 22e. ADDRESS
SINAI HOSP OF BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C. March F/H, Inc. West | | | | ADDRESS
4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
SEP 26 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |

266035

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25475
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|---|--|--------------------------------|--|---|--|------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Solomon T. W. Ringgold | | | | | | | | 9 17 19 85 | | | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| MALE | BLACK | 11 28 10 | | 74 YRS. | | | | | | 9 17 19 85 | | | | | | M | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| RIDGELEY MARYLAND | | U.S.A. | | | | | | Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 903 McDonough Street | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | |
| MARYLAND | | | | BALTIMORE | | | | 903 Mc DONOUGH ST 21205 | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| HENRY RINGGOLD | | | | MARTHA | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| NO | | | | 220-22-9543 | | | | INEZ CRADDOCK 3417 ELMORA AVE 21213 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | TITLE (SPECIFY)
Assistant | | | | DATE
SIGNED | | | | 9/17/85 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St. Balto. MD. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | | | 9-20-85 | | | | BALTIMORE CEMETERY | | | | BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | | | | | SEP 19 1985 | | | | [Signature] | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

200003

20% COTTON FIBER

ONOT

WATER



280104

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 4 7 6

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | | 2a DATE OF DEATH | | | 2b HOUR | | | |
| VINCENT T. RIVERS | | | SEPTEMBER 30, 1985 | | | M | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | |
| MALE | | BLACK | | MAR. 13, 1922 | | 63 | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| VIRGINIA | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | 1936 WEST FAYETTE STREET | | | | RETIRED | | POLICE FORCE | |
| 13a STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | |
| MARYLAND | | | N/A | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | 13e STREET ADDRESS | | | |
| TROY RIVERS | | | ADELINE STUBBS | | | 1936 W. FAYETTE ST. 21223 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | |
| YES | | | WW II | | 216-16-6839 | | RUBY BOND RIVERS 1936 W. FAYETTE ST. 21223 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bladder carcinoma</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<u>Richard J. Jones</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
10/3/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Richard J. Jones</u> | | | | | | 22e ADDRESS
<u>Johns Hopkins Hospital Baltimore, MD</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | |
| BURIAL | | | 10/4/85 | | GARRISON FOREST | | OWINGS MILLS, MD. | | |
| 24 FUNERAL DIRECTOR
NAME | | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| LEROY O. DYETT & SON 4600 LIB. HIGHTS. AVE. | | | | | | OCT 3 1985 | | <u>Lelia Davidson-Randall</u> | |

MEDICAL CERTIFICATION

99

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Paper may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of this.

280104



RECEIVED 1978

WORLD WIDE

259117

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 4 7 7

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|-------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIE L ROBERSON | | | 2a. DATE OF DEATH
MONTH 9 DAY 7 YEAR 85 | | 2b. HOUR
11:15 P.M. | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH 10 DAY 31 YEAR 46 | | 6. AGE (IN YEARS LAST BIRTHDAY)
38 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) SC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
UNIVERSITY STREET HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) ASSEMBLER | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | | |
|--|--|--|--|--|---------------------------------------|--|---|--|---|--|--|
| 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1928 Walbrook Ave. 21217 | | |
| 14. FATHER'S NAME
FIRST SINKLER MIDDLE LAST ROBERSON | | | 15. MOTHER'S MAIDEN NAME
FIRST LILLIE MIDDLE LAST PACK | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(S, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) 214-44-2547 | | | 17. INFORMANT ADDRESS
LILLIE MAE ROBERSON 1928 WALBROOK AVE. | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22. I certify that (I) (this hospital) attended the deceased from **9/7**, 19 **85**, to **9/7**, 19 **85**, that (I) (we) lost
saw the deceased alive on **9/7**, 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|--|--|--|--|-----------------------------------|--|
| 22b. SIGNATURE
Edward B. Bolgiano MD | | DEGREE | | 22c. DATE SIGNED
9/8/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD B. BOLGIANO | | 22e. ADDRESS
UNIV OF MARYLAND HOSPITAL | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
9/12/85 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY ANNE ARUNDAL CO. MD | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
|--|--|-----------------------------|--|--|--|--|--|

| | | | | | |
|---|--|---|--|----------------------------|--|
| 24. FUNERAL DIRECTOR
NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | 25b. REGISTRAR'S SIGNATURE | |
|---|--|---|--|----------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

111223

RECEIVED

QND

WAT



274090

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 5 2 5 4 7 8

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Eunice ROBERTSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 23, 1985 | | 2b. HOUR PM
2:40 M | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 1 16 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Judge Farrar | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sallie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
214-22-6090 | | 17. INFORMANT
ADDRESS
Rosa Robertson 828 N. Luzerne Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular disease.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d) Atherosclerosis of blood vessels. | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-23-85 , to 9-23-85 , that (I) (we) lost
saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Darshan S. Saluja | | DEGREE
MD | | 22c. DATE SIGNED
9/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Darshan S. Saluja, M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
9/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Wm C March F/H Inc. 1101 E North Avenue | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
SEP 27 1985 | |

351030

Q3819 MOF100 2102

WILSON
CHIEF



274166

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|--|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CARROLL T. ROBINSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/13/85 | | 2b. HOUR
11:45 A | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 13 1926 | | |
| 6. AGE
(IN YEARS LAST BIRTHDAY)
58 YRS. | | 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
deliveryman | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
bldg. supply | | 13a. STATE
Md. | | | | |
| 13b. COUNTY
Dor. | | 13c. CITY OR TOWN
Cambridge | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
1310 Colonial Ave. 21613 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Abel Robinson | | | | |
| 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Willey | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | |
| 16b. SOCIAL SECURITY NO.
213-22-7795 | | 17. INFORMANT
ADDRESS
Nanalee Robinson Item # 13 | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CRAVIAL ARTERIAL-VENOUS MALFORMATION</u> <u>Sygs.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | |
| 19a. DATE OF OPERATION
9/12/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ARTERIAL-VENOUS MALFORMATION | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> 19 <u>85</u> , to <u>9/13</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/13</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>B. Szura</u> | | DEGREE | | 22c. DATE SIGNED
9/13/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRIAN SZURA, M.D. | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
9/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cambridge Dor. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
THOMAS FUNERAL HOME CAMBRIDGE MD. | | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | |

MEDICAL CERTIFICATION

19

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a death investigation will be required.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

[Faint, illegible text, likely bleed-through from the reverse side of the page]

280070

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 25480
 REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---------------------------------|--|-------------------------|--|----------|--|
| 1- FOR STATE REGISTRAR | | 2- DECEASED NAME (TYPE OR PRINT) | | 3- SEX | | 4- RACE | | 5- DATE OF BIRTH | | 6- AGE (IN YEARS LAST BIRTHDAY) | | 7a- DATE KNOWN OF DEATH | | 7b- HOUR | |
| | | Clara Robinson | | F | | B | | 11 19 98 | | 86 YRS. | | 9/ 27/ 19 85 | | 7:15 P | |
| 7a- BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b- CITIZEN OF WHAT COUNTRY? | | 8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9- BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City, | | | | | | | | | |
| 10- CITY OR TOWN OF DEATH | | 11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b- KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | 501 Dolphin St. | | | | | | | | | | | | | |
| 13a- STATE | | 13b- COUNTY | | 13c- CITY OR TOWN | | 13d- INSIDE CITY LIMITS? | | 13e- STREET ADDRESS | | | | | | | |
| Maryland | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 501 Dolphin St. Apt 1103 | | | | | | | |
| 14- FATHER'S NAME | | 15- MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Mondie | | Unknown | | | | | | | | | | | | | |
| 16a- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b- SOCIAL SECURITY NO. | | 17- INFORMANT | | ADDRESS | | | | | | | | | |
| no | | 212-28-2868 | | Grace Hilliard | | 1820 Division St. | | | | | | | | | |
| 18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Arteriosclerotic Cardiovascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | | | (c) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | |
| 19a- DATE OF OPERATION | | 19b- CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20- AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a- EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b- TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d- INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e- PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f- LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a- I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED | | 9/28/85 | | | | | |
| ACTUAL SIGNATURE | | Margarita A. Korell, M.D. | | ADDRESS | | 111 Penn St. | | | | | | | | | |
| 23a- BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b- DATE | | 23c- NAME OF CEMETERY OR CREMATORY | | 23d- LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| BURIAL | | 10-3-85 | | Arbutus | | Arbutus | | | | | | Md. | | | |
| 24- FUNERAL DIRECTOR NAME | | ADDRESS | | 25a- DATE REC'D. BY REGISTRAR | | 25b- REGISTRAR'S SIGNATURE | | | | | | | | | |
| W.C. MARCH F/H CO. | | 1101 E. NORTH AVE. | | OCT 2 1985 | | Richard Davidson-Randall | | | | | | | | | |

580070

UNITED

WATER TIGHT

REBUILT MOTOR 200





200

277157

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|--------|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
LEROY | MIDDLE | LAST
ROBINSON | 2a. DATE OF DEATH
MONTH DAY YEAR
SEP 28 1985 | | 2b. HOUR
7⁰⁵ PM | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 29 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CIRCLES GENERAL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
RUBBER CO. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2432 W. COLDSRING 21215 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEROY ROBINSON, SR. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
MARIE LANE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | |
| 16b. SOCIAL SECURITY NO.
212 22 7376 | | 17. INFORMANT
ADDRESS
NATHANIEL GIBBS, 2432 W. COLDSRING LANE | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRUNCHOPNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: COPD ACUTE TUBER. MENING. | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (the deceased) attended the deceased from 19 20 Jan to 29 Jan 19 85 , that (1) (the deceased) last saw the deceased alive on 29 Jan 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (I) (we) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
 | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
9-29-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARTHUR T. VERBUM MD | | 22e. ADDRESS
3640 FORDS LANE 21215 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
10-4-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEMORIAL PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE COUNTY | | |
| 24. FUNERAL HOME OR PERSONAL ADDRESS
MUTTER & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PARKWAY, BALTO., MD 21216 | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

221127

RECEIVED OCT 20 1952



RECEIVED OCT 20 1952

X

OCT 3 1952

267106

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25482

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|----------------|--|--|--------------------|---|---|-------------------------------|--|--------------------------------|---|---------------------------------------|---|---------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Louis | | | MIDDLE
Robinson | | | LAST
Robinson | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 9-18 1985 | | | 2b. HOUR
M | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 28 01 | | | 6. AGE (IN YEARS)
LAST BIRTHDAY
84 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
9-18 1985 | | | 2d. HOUR
7:35 M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1516 Traction Street | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
1516 Traction Street 21217 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Robinson | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | | | | | | 16b. SOCIAL SECURITY NO.
250-05-5625 | | | | 17. INFORMANT
ADDRESS
Azalee Bass 6615 Spring Mill Cir. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
9-18-85 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(S) BURIAL | | | | 23b. DATE
9/20/85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill Cemetery | | | | 23d. LOCATION
BALTIMORE CO, COUNTY STATE
Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | | | | | | | | | ADDRESS
1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 20 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH PAGE 4, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/B4
25M

BP

DHMH - 17
(VR A15 ME (5))



QWOB VITAFILIP

43617 101700 X02

252113

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25483

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|------------------|---|---|---|---|---|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary Louise Robinson | | | 2a. DATE OF DEATH
KNOWN <input type="checkbox"/> ESTI-
MATED XX 9-2 19 85 | | | 2b. HOUR
M | | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
11 16 22 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
62 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
9-3 19 85 | 2d. HOUR
12:55 P. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
427 Watty Court | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
427 Watty Ct. 21201 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mark Johnson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Ethel J. Carlisle 3408 Meadowbridge Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)
<u>Obesity</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<u>Dennis F. Smyth</u> | | TITLE (SPECIFY)
M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED
9-4-85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-7-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Richmond, Virginia | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Bailey-Douglass Funeral Home 1348 Calhoun St. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Lelia Davidson-Randall</u> | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

SECRET



269043

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARIE VICTORIA ROBINSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 19 85 | | | 2b. HOUR
140 M | | | |
| 3 SEX
FEMALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
5-7-1901 | | 6 AGE (IN YEARS LAST BIRTHDAY)
84 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY
PRIV. FAMILY | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS
3210 PRESSTMAN STREET, 21216 | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
TOMMIE ROBINSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAGGIE REID | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-32-2863 | | 17. INFORMANT
ADDRESS
MARGARET ENGLISH, 3210 PRESSTMAN STREET | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration Respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonitis, acute</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Strangulated Femoral Aemia</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION
9/19/85 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
strangulated femoral hernia | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/18</u> 19 <u>85</u> , to <u>9/19</u> 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>9/19/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Miles G. Harrison, M.D. | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/19/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MILES G. HARRISON JR. | | | 22e. ADDRESS
2300 Calverton Blvd Suite 104 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
9-24-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEMORIAL PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE COUNTY | | |
| 24. FUNERAL DIRECTOR
NUTTER & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PARKWAY, BALTO., MD 21216 | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |

MEDICAL CERTIFICATION

70
39
35
300
2
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

SECRET



REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARVIN J. ROEDER | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 3, 1985 | | 2b. HOUR
M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 8, 1922 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
63
YRS | | 7a. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7b. IF UNDER 24 HRS
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD. | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Distributing | |
| 13. CITY OR TOWN OF DEATH
Baltimore | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5919 Meadowood Road, 21212 | | 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | |
| 16. STATE
Maryland | | 17. COUNTY
Baltimore | | 18. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 19. FATHER'S NAME FIRST MIDDLE LAST
Edward A. | | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary K. | | 21. STREET ADDRESS / ZIP CODE
5919 Meadowood Road, 21212 | |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes | | 23. SOCIAL SECURITY NO.
215-12-7151 | | 24. INFORMANT ADDRESS
Dr. Virginia V. Roeder, same as #13e | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Respiratory Arrest
Ankytrophis lateral Sclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 minute
1 year | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 26a. DATE OF OPERATION
/ | | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED
/ | | 26c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 27b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. / 19 | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)
/ | |
| 27d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 27e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)
/ | | 27f. LOCATION
STREET CITY OR TOWN COUNTY STATE
/ | |
| 28. I certify that (I) (this hospital) attended the deceased from July , 19 84 , to 9-3 , 19 85 , that (I) (was) lost saw the deceased alive on 8-29 , 19 85 , and that in my (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death. | | | | | |
| 29. SIGNATURE
Keith A. Manley | | DEGREE
/ | | 30. DATE SIGNED
9-3-85 | |
| 31. PHYSICIAN'S NAME (TYPE OR PRINT)
Keith A. Manley, M.D. | | 32. ADDRESS
1818 Pot Spring Road, Timonium, Md. 21093 | | | |
| 33. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 33b. DATE
9-3-85 | | 33c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Park | |
| 33d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | 34. DATE REC'D. BY REGISTRAR
SEP 5 1985 | | | |
| 35. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | 36. REGISTRAR'S SIGNATURE
J. W. Anderson-Randall | | | |

BP

231533



WILSON
COTTON FIBER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR ITEM 22a
STATE-7-86 cn
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|--|--------------------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Arthur (NMF) ROGERS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-25-85 | | 2b. HOUR
MIN.
1:26 P.M. | | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
8 25 50 | | 6 AGE (IN YEARS LAST BIRTHDAY)
35 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNKNOWN | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1406 N. GAY 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ARTHUR ROGERS SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JEANETTE JOHNSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNKNOWN | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
LAWERENCE JOHNSON 1406 N. GAY ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
XXXX IMMEDIATE CAUSE (a) cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF pulmonary edema
(b) A.R.D.S. And
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF heart drowning
(c) pulmonary edema A.R.D.S. And | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 9-25- 1985 | | 21c. HOW INJURY OCCURRED (If you state OF INJURY IN ITEM 18, PART I OR PART 2)
Observed by police to have jumped into inner harbor | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Inner Harbor Area | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Baltimore City MD | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25 1985 saw the deceased alive on 9/25 1985 and that in (my) (our) (my) (our) last view of the deceased was on 9/25 1985 that (I) (we) last saw the deceased on 9/25 1985 and that in (my) (our) last view of the deceased was on 9/25 1985 and that in (my) (our) last view of the deceased was on 9/25 1985 | | | | | | | | | |
| 22b. SIGNATURE
OK [Signature] MD | | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
J J KMETZ 20 | | | | 22d. ADDRESS
U. MD. HOSPITAL | | 22e. DATE SIGNED
9-25-85 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9/30/85 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CREM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WILLIAM C. BROWN COMM. FIA 1206-08 W. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 02 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

280149

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, though it may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers, pages 1 and 2, and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP 1347

270015

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|---|---|--|--|-----------------------------------|---|----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
HATTIE L ROGERS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 21, 1985 | | | 2b. HOUR
P
1:14
M | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
6 3 17 | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Durham N.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Rogers | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Steptoe | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
225-30-4199 | | 17. INFORMANT
ADDRESS
Hazel R. Bailey 1719 Cliftview ave. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiogenic Shock

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24 HOURS

DUE TO, OR AS A CONSEQUENCE OF

(b) Myocardial infarction

24 HOURS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

MEDICAL CERTIFICATION

| | | | | | |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I (this hospital) attended the deceased from 9/15, 19 85, to 9/21, 19 85, that s/he (we) lost
saw the deceased alive on 9/21, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Kevin Horgan | | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/21/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KEVIN HORGAN | | 22e. ADDRESS
c/o JOHNS HOPKINS HOSPITAL | | | |

| | | | |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/26/85 | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore County Md. |
| 24. FUNERAL DIRECTOR
NAME
W.C. March F/H | | ADDRESS
1101 E. North ave. | 25a. DATE REC'D. BY REGISTRAR
SEP 25 1985 |
| | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and released to the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene. To burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

310072



275070

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #1. 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP
DHMH - 17
(VR A15 ME (5))

 1- FOR
STATE
REGISTRAR

 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25488

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|-----------------|--|--|---|--|---|----------------|--|--|---|--|---|-----------------------|--|--|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Joseph | | | MIDDLE
L. | | | LAST
Rolfes | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
9/ 27/ 19 85 | | | 2b. HOUR
11:19 P M | | | | | | | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
9/18/1938 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
47 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9/ 27/ 19 85 | | | 11:19 P M | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital Shoch Trauma | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESPERSON | | | | 12b. KIND OF BUSINESS OR INDUSTRY
INSURANCE | | | | | | | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
HARFORD | | 13c. CITY OR TOWN
FOREST HILL | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1904 PARKWOOD DRIVE 21050 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH CHARLES ROLFES | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARION RACHEL COMI | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | | | | | 16b. SOCIAL SECURITY NO.
214 38 2625 | | | | | | 17. INFORMANT
ADDRESS
PATRICIA ROLFES 1904 PARKWOOD DRIVE
FOREST HILL MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8147 IMMEDIATE CAUSE (a) Multiple Injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR XX MONTH DAY YEAR
9:10 P.M. 9/27/ 19 85 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject pedestrian struck by auto | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
roadway | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Belair Rd. South of Martin Ave., Balto.Co., Md | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED
9/28/85 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | | 23b. DATE
10/1/1985 | | | | 23c. NAME OF CEMETERY OR CREMATORY
MOST HOLY REDEEMER | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
DIPPEL FUNERAL HOMES 7110 BELAIR RD. BALTO. MD. | | | | 25a. DATE REC'D. BY REGISTRAR
21206 SEP 30 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | | | | | | | | | | | | | | | |

1981 COLLECTION

NOV 1981



259142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LOUIS ROSENBLATT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09 09 85 | | 2b. HOUR
3 27 P.M. |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
04 27 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
COMARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PROPRIETOR | | 12b. KIND OF BUSINESS OR INDUSTRY
BOND WALLPAPER CO. |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES NO |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MORIS ROSENBLATT | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EVA COHEN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. 21-2-81-1354
004-60-0541 | | |
| 17. INFORMANT
TILMAN ROSENBLATT | | | 519 WYNGATE RD. TIMONIUM, MD 21093 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intractable ventricular arrhythmias</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>myocardial infarction.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-3-1985</u> to <u>9-9-1985</u> that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Meenakshi Patel | | DEGREE
MD | | 22c. DATE SIGNED
9-9-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MEENAKSHI PATEL | | 22e. ADDRESS
SINAI HOSPITAL, BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
SEPT. 11, 1985 | | 23c. NAME OF CEASEMENTARY
CHIZUK AMUNO | |
| 23d. LOCATION
BALTIMORE | | COUNTY MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendell | | | | | |

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove all other papers, pages 2 and 3, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the State Dept. of Health and Mental Hygiene within 24 hours after death.

BP

SALES

3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 4 9 0
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|---------------------|---|--|--|--------------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Harry Ross | | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
9 27 1985 | | | | 2b. HOUR
M | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
2 28 29 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
56 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
9 27 1985 | | 7d. HOUR
5:04A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Buckingham Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2031 E. Preston Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2031 E. Preston St. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Holman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy Ross | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
224-34-5328 | | 17. INFORMANT ADDRESS
Ross | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (b) _____ | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) _____ | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that I took charge of the remains described above, and on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion

TITLE (SPECIFY) **Acting Chief** MEDICAL EXAMINER

DATE SIGNED **9/27/85**

ACTUAL SIGNATURE *Thomas D. Smith*

EXAMINER'S NAME (TYPE OR PRINT) **Thomas D. Smith, M.D.** ADDRESS **111 Penn St. Balto.MD.**

| | | | | |
|--|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
10-3-85 | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FORREST | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mill Md |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W.C. MARCH F/H CO. 1101 E. NORTH AVE. | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | 25b. REGISTRAR'S SIGNATURE
<i>John A. ...</i> |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

280072

ROYAL COLLEGE

CHITRAWA BOND



273072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 4 9 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| Marie G. Ross | | | Sept. 23, 1985 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White, | | Aug. 17, 1919 | | 66 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 1932 Light St. Balto. Md. | | | | Homemaker | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | Baltimore | | Baltimore | | 13e. STREET ADDRESS / ZIP CODE 21230 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| Emerich ---- Matusky | | | Gazella ---- Johnson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | 216-10-9530 | | Mr. Douglas Ross, Same as above | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) Endometrial Carcinoma, metastatic 1 Yr. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/5 1985 to 9/23 1985, that (I) saw the deceased alive on 9/14 1985, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Louis E. Grenzer | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis E. Grenzer | | | 22e. ADDRESS 1101 N. Calvert St. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/26/1985 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave. | | | 25a. DATE RECD. BY REGISTRAR SEP 26 1985 | | | 25b. REGISTRAR'S SIGNATURE | | | |

283001

1-
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25492

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|---|---|--|---|--|---|--|---|-----------------------------|--|--|----------------------------|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARISE J. ROSS | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
9 29 1985 | | | 2b. HOUR
M | | | | | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 26 26 59 YRS. | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
IF UNDER 1 YR. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
9 30 1985 | | | 2d. HOUR
A M
9:39 A M | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2522 Rellim Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
M.D. | | | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2522 Rellim Rd 21204 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WALTER CARLSON | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elsie Seaborg | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
357-14-0651 | | | | 17. INFORMANT
ADDRESS
Gordon Becker | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Ann M. Dixon | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED
9-30-85 | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | 23b. DATE
10-7-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO M.D. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Name
Kath Funeral Home | | | | ADDRESS
5209 York Rd | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 8 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John T. ... | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

252105

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--------|-----|----------|--------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | | |
| SHIRLEY | | ROSS | | | | | | 9 | | - | 2 | - | 0925AM | | |
| 3 SEX | | F | | 4 RACE | | B | | 5. DATE OF BIRTH | | MONTH | DAY | YEAR | 6 AGE (IN YEARS LAST BIRTHDAY) | | |
| | | | | | | | | 7 | | 11 | 42 | 43 | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U. S. A. | | | | Baltimore City | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | University of Maryland Hosp | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS / ZIP CODE | | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2210 Norfolk St | | 21230 | | | | | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| George | | Wilda | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | | | | | |
| | | 215-40-7042 | | Wilda Dorsey | | 2428 Annor Court. | | | | | | | | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) | | PART I. DEATH WAS CAUSED BY | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| | | | | CARDIAC ARREST | | RENAL FAILURE | | | | | | | | | |
| | | | | STAGE III S Squamous Cell Ca of Cervix - metastatic | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) _____ the body after death. | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED | | | | | | | | | |
| Doris Jerec | | MD | | | | Sept 2, 85 | | | | | | | | | |
| 22d PHYSICIAN'S NAME | | 22e ADDRESS | | | | | | | | | | | | | |
| Doris Jerec | | 22 S. Greene St | | Balt, MD | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| Burial | | 9-7-85 | | Mt. Auburn Cemetery | | Baltimore | | | | | | Maryland | | | |
| 24 FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| Bailey-Douglass Funeral Home | | | | 1348 Calhoun St. | | SEP 5 1985 | | John Davidson-Randall | | | | | | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of same.

301102



WILKINSON

20% COTTON LITE

following information

1. 1. 1. 1. 1. 1.

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12. 12. 12. 12. 12. 12.

1210 23-548

1210

SEP 8 2007

2 5 4 9 4
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER THE DEATH. IF AN UNREASONABLE DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR REPORT. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND | | | | | | | | | | 25494 | |
|--|--|---------|--|---|--|-------------------|--|---|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 85 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | 2c. DATE OF DEATH | |
| Clay | | | | A. | | | | Roulhac | | XX MONTH DAY YEAR 9-8 19 85 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 7d. HOUR | |
| male | | black | | 3 10 60 | | 25 YRS. | | MONTHS DAYS HOURS MIN. | | 1:10 p.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED | | | |
| North Carolina | | | | U.S.A. | | | | XX NEVER MARRIED | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION | | | |
| Baltimore | | | | Constellation Dock-Inner Harbor | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| Maryland | | | | | | | | Baltimore | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. SOCIAL SECURITY NO. | | | |
| Ulysses | | | | Roulhac | | | | Mary Allen | | | |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 17. INFORMANT | | | | 18. ADDRESS | | | |
| NO | | | | Paula Roulhac | | | | 34 Bishops Gate Court | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Drowning | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | 12:40PM 9-8 19 85 | | | | subject jumped into water | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | |
| | | | | water | | | | Constellation Dock-Inner Harbor, Balto., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE | | | |
| [Signature] | | | | Assistant | | | | 9-9-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | 23d. LOCATION | | | |
| Gregory R. Kauffman, M.D. | | | | 111 Penn St., Balto., Md. | | | | 23d. LOCATION | | | |
| 23a. BURIAL | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| BURIAL | | | | 9/16/85 | | | | King Memorial Park | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm C March F/H Inc. 1101 E North Avenue | | | | SEP 13 1985 | | | | [Signature] | | | |

110005



275088

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>William</u> MIDDLE <u>E.</u> LAST <u>Ruby</u>
<u>WILLIAM E. RUBY</u> | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>September 26, 1985</u> | | 2b. HOUR
<u>M</u> | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>Aug. 20, 1913</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 6. AGE (IN YEARS (LAST BIRTHDAY))
<u>72</u> YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>St. Agnes Hospital</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Mechanic Maintenance</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>A.A.</u> | | 13c. CITY OR TOWN
<u>Pasadena</u> | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<u>266 Beachwood Road 21122</u> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>William Henry Ruby</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Lottie Marie Smith</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<u>Yes WW II</u> | | 16b. SOCIAL SECURITY NO.
<u>705-03-5061</u> | | 17. INFORMANT
ADDRESS
<u>Lina T. Ruby Same as # 13</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>DIFFUSE BILATERAL BRONCHOPNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>ACUTE RESPIRATORY DISTRESS SYNDROME</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>DAYS</u>
<u>WEEKS</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> , 19 <u>85</u> , to <u>9/26</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Steven H. Pearlman</u> | | DEGREE
<u>M.D.</u> | | 22c. DATE SIGNED
<u>9/27/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>STEVEN H. PEARLMAN</u> | | 22e. ADDRESS
<u>ST. AGNES HOSPITAL, 800 S. CAROL AVE.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Cremation</u> | | 23b. DATE
<u>9/27/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Security Process</u> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Catonsville, Balto., MD</u> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Cremation Society of MD</u> | | ADDRESS
<u>Balto., MD</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>SEP 30 1985</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2

277129

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|---|------------------------------|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM AUGUST RUFF, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 29 85 | | | 2b. HOUR
5:08 PM | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 2 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 23 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Arbutus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1307 Elm Road 21227 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Ruff | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Unavailable | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
213-09-9333 | |
| 17. INFORMANT
Rita L. Ruff | | | ADDRESS
1307 Elm Road | | | 21227 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) RIGHT LOWER LOBE PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DAYS

DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> , 19 <u>85</u> , to <u>9/29</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/29</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Steven H. Pearlman | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/30/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven H. Pearlman | | | | 22e. ADDRESS
ST. AGNES HOSPITAL 300 S. CALVERT ST. | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
James H. Anderson | |

STATES




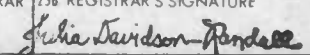
266024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|------------------|--|--|---|--|---|-----------------|-------------------------------|--|---|--|--|--------------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
CHARLES | | | MIDDLE
O. | | | LAST
RUSSELL | | | 2a. DATE KNOWN
OF DEATH
ESTI-
MATED
<input checked="" type="checkbox"/> 9-13-85 ₁₉ | | | 2b. HOUR
M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 7 14 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD
9-13-85 ₁₉ | | | 2d. HOUR
1:50 _{PM} | | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | | | |
| 11. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Bricklayer | | | | 12b. KIND OF BUSINESS
OR INDUSTRY
Masonry | | | | | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
335 S. Payson Street 21222 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oscar Russell | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mattie Carroll | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
WW II 212-09-8811 | | | | 17. INFORMANT
ADDRESS
Naomi F. Russell 335 S. Payson St. 21223 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic hypertensive cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>chronic alcoholism</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE 9-15-85
SIGNED | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
9/18/85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | | | ADDRESS
4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY PENK IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. REPAIR PAGE 3 FOR 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1951 OTTOD 2ND

WINTER



2ND

259154

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 4 9 8

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KRISTEN RUSSELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPT. 11, 1985 | | | 7b. HOUR
11:28a
M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 17, 1974 | | 6. AGE (IN YEARS LAST BIRTHDAY)
10 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hollywood, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
St. Mary's | | 13c. CITY OR TOWN
Hollywood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
P.O. Box 151 20636 | |
| FATHER'S NAME
FIRST MIDDLE LAST
Robert R. Russell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Darlene Norris | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
Darlene Russell | | ADDRESS
Same as 13e. | | | | |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral Anoxia
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute increased intracranial pressure | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11:28 AM 9/11/85
24 hrs.
7:15 AM 9/10/85 | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10 , 19 85 , to 9/11 , 19 85 , that (I) (we) last saw the deceased alive on 9/11 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Reid Thompson | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9/11/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Reid Thompson, MD | | | 22e. ADDRESS
Johns Hopkins Hosp., Baltimore, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Sept. 14, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
St Johns | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hollywood St. Mary's, MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W. Clarke Mattingley Leonardtown, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
SEP 13 1985 Julia Davidson-Randell | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RUSSELL, KRISTEN

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3, should be detached for use at the burial or cremation. Then please deliver carbon papers, pages 1 and 2, to the funeral home first. If the death occurred more than 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

121825



269083

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HELEN ELIZABETH RYAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/20/85 | | 2b. HOUR
4:00
M |
| 3 SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
11/11/02 | | 6 AGE (IN YEARS LAST BIRTHDAY)
83 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore |
| 14. FATHER'S NAME
Matthew | | 15. MOTHER'S MAIDEN NAME
Ellen | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR (LINEAR NUMBER))
NO | | 16b. SOCIAL SECURITY NO.
215-05-3677 | | 17. INFORMANT
Milton J. Ryan | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |

MEDICAL CERTIFICATION

| | | | |
|--|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED: (Enter signature of INJURY in ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE FARM ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Sept 16</u> , 19 <u>85</u> , to <u>Sept 20</u> , 19 <u>85</u> , that (1) we last saw the deceased alive on <u>Sept 20</u> , 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) we (did) did not view the body after death. | | | |
| 22b. SIGNATURE
<u>Armando Hool</u> | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
9/20/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARMANDO HOOL | | 22e. ADDRESS
3001 S. Hanover St. Baltimore MD. | |

| | | | |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9/23/85 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | ADDRESS
4107 Wilkens Ave. | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles H. ...</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

85 SEP 20 A 9:40

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



200003 100000



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

25500
REG. NO.

FOR
STATE
REGISTRAR

277053

| | | | | | | | | | | | | | | |
|---|--|-------------------------|---|--|--|---|--|---|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CORIAN | | | FIRST
SALMON | | | LAST | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
9 25 1985 | | | 2b. HOUR
M
6:15
M | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 14 82 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
3 | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 25 1985 | | 7d. HOUR
M
6:15
M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY
EDGEWATER | | 13c. CITY OR TOWN
B | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 37 LORING CT. | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Salmon | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Flourence STERN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Thomas Salmon 5715 Rubin Ave. | | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Intracerebral hemorrhage**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) **Ruptured arteriovenous malformation**

DUE TO, OR AS A CONSEQUENCE OF


(c)

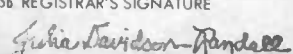
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE  TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **9-26-85**
EXAMINER'S NAME (TYPE OR PRINT) **Ann M. Dixon, M.D.** ADDRESS **111 Penn St., Balto., MD 21201**

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/31/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME E. L. Phillips ADDRESS 1721 N. Monaca | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 1 1985 | | 25b. REGISTRAR'S SIGNATURE
 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

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DHMH - 17
(VR A15 ME (5))

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REXINGTON COLTON 1825

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Wm

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Wm

269112

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
STEPHEN MARK SANDOZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 19 85 | | | 2b. HOUR
9:40 A M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 14 1956 | | 6. AGE (IN YEARS LAST BIRTHDAY)
29 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Ellicott City | |

| | | | |
|---|--|---|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walton NMI Sandoz | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Baker | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216/46/4991 | |
| 17. INFORMANT
Elizabeth B. Sandoz (Mother) | | ADDRESS
(Same as 13e) | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) INTRAVENTRICULAR SEPTAL DEFECT | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) DOWN'S SYNDROME | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-16- 19 85 to 9-19- 19 85 , that (I) (we) last saw the deceased alive on 9-18- 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R M ALHOTRA | | | | DEGREE | | 22c. DATE SIGNED
9.19.85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R M ALHOTRA | | | | 22e. ADDRESS
900 CATON AVE, BALT, MD 21229 | | | |

| | | | | | | | |
|---|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
9/20/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Walter Brooks Bradley Inc. Balto., Md. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card from front of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Medical examiner must be notified at once. IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic cause of death, a medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles C Ludwig Schacker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 27 85 | | 2b. HOUR
8:31A M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 03 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
800 Southerly Road 21204 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- 705-09-0014 | | 17. INFORMANT
ADDRESS
Elizabeth Schacker 800 Southerly Way 21204 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) CALCIFIC ATHEROSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DAYS
YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James E Taylor | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
9/27/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES E TAYLOR, M.D. | | | | 22e. ADDRESS
ST. AGNES HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
09-30-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
HUBBARD FUNERAL HOME, INC. 4107 Wilkens Avenue 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | | 25b. REGISTRAR'S SIGNATURE
G. H. Davidson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

BP

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UNITED STATES MARINE CORPS



262128

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25503
REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|------------------------------------|--|--|--|------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2. DATE KNOWN
OF DEATH ESTI-
MATED | | | | 3. DATE OF DEATH
MONTH DAY YEAR | | | | 4. HOUR
M | | | |
| RUTH
BRAUN
SCHAEFFLER | | | | 9 10 1985 | | | | 9 11 1985 | | | | 7:15 P M | | | |
| 5. SEX | | 6. RACE | | 7. DATE OF BIRTH
MONTH DAY YEAR | | 8. AGE (IN YEARS
LAST BIRTHDAY) | | 9. IF UNDER 1 YR.
MONTHS DAYS | | 10. IF UNDER 24 HRS.
HOURS MIN. | | 11. DATE PRONOUNCED
DEAD | | | |
| Female | | White | | 3 10 09 | | 76 YRS. | | | | | | 9 11 1985 | | | |
| 12. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | | | 13. CITIZEN OF WHAT COUNTRY? | | | | 14. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 15. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore City MD | | | |
| 16. CITY OR TOWN OF DEATH | | | | 17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 18. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | | 19. KIND OF BUSINESS
OR INDUSTRY | | | |
| Baltimore | | | | 3952 Benzinger Rd. | | | | Crossing Guard | | | | Baltimore City Schools | | | |
| 20. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | 21. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| 22. STATE | | | | 23. COUNTY | | | | 24. CITY OR TOWN | | | | 25. INSIDE CITY LIMITS? | | | |
| Maryland | | | | | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 26. FATHER'S NAME
FIRST MIDDLE LAST | | | | 27. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | 28. STREET ADDRESS | | | | 29. ADDRESS | | | |
| John Braun | | | | Carrie Butcher | | | | 12 Oaklee Village 21229 | | | | 21229 | | | |
| 30. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 31. SOCIAL SECURITY NO. | | | | 32. INFORMANT | | | | 33. ADDRESS | | | |
| No | | | | 214-01-3831 | | | | Albert L. Rheb | | | | 3352 Wilkens Ave. 21229 | | | |
| 34. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | 35. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 36. DATE OF OPERATION | | | | 37. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 38. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 39. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 40. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 41. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 42. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 43. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 44. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 45. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| 46. ACTUAL SIGNATURE | | | | 47. TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | 48. DATE SIGNED | | | | 49. 9-12-85 | | | |
| 50. EXAMINER'S NAME
(TYPE OR PRINT) | | | | 51. ADDRESS | | | | 52. LOCATION
CITY OR TOWN COUNTY STATE | | | | 53. DATE REC'D. BY REGISTRAR | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto. MD 21201 | | | | Baltimore | | | | Maryland | | | |
| 54. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 55. DATE | | | | 56. NAME OF CEMETERY OR CREMATORY | | | | 57. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 9/16/85 | | | | Baltimore Natl. Cem. | | | | Baltimore Maryland | | | |
| 58. FUNERAL DIRECTOR
NAME ADDRESS | | | | 59. DATE REC'D. BY REGISTRAR | | | | 60. REGISTRAR'S SIGNATURE | | | | 61. DATE REC'D. BY REGISTRAR | | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 21229 | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP
DHMH - 17
(VR A15 ME (5))

SEP 16 1985

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20% COTTON LEEB



MADE IN U.S.A.

303108

267032

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | |
|---|---|---|--|--|--------------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST
ELIZABETH M. SCHLAFFER | | | MONTH DAY YEAR
SEPTEMBER 16, 1985 | | | 2am M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | | | 7. UNDER 1 YEAR | | |
| FEMALE | WHITE | MONTH DAY YEAR
OCT. 27 1890 | 94 | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD. | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | LONG GREEN NURSING HOME | | | HOMEMAKER | | | - | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. INSIDE CITY LIMITS? | | | 13c. STREET ADDRESS / ZIP CODE | | |
| 13a. STATE CITY OR TOWN
MD. BALTIMORE | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 2201 PELHAM AVE. 21213 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BERNARD RETHMAN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| NO | | | 213-74-6541 | | | BARBARA MARTIN (NIECE) SAME ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 day |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/15 19 85 to 9/16 19 85 that (I) (we) last saw the deceased alive on 9/15 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
DR. WM. G. HELFRICH | | | | | | DEGREE
MD | | 22c. DATE SIGNED
9/17/85 |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22c. ADDRESS | | |
| DR. WM. G. HELFRICH | | | | | | 5006 Roland Avenue | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| BURIAL | | | 9/18/85 | | | HOLY REDEEMER | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | 23e. DATE REC'D. BY REGISTRAR | | | 23f. SIGNATURE OF REGISTRAR | | |
| BALTIMORE MD. | | | SEP 20 1985 | | | Richard J. [Signature] | | |
| 24. FUNERAL HOME NAME ADDRESS
SCHMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner must be notified of same.

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2005003

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 5 0 5
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
(NETTIE) ANNETTE V. SCHOELKOPF | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 / 12 / 85 | | | 2b. HOUR
805 P M | | | | |
| 3 SEX
F | | 4 RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 14 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 89 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Co., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Turnbaugh | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Blanche | | | 13e. STREET ADDRESS / ZIP CODE
Balto., Md.
41 N. Monastery Ave. #21229 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-76-5517 | | 17. INFORMANT
41 N. Monastery Ave. - Balto., Md.
Louis J. Schoelkopf #21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 WEEKS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
MALNUTRITION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12 19 85 to 9/12 19 85 that (I) (we) last saw the deceased alive on 9/12 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Walter J. Alt, M.D. | | | DEGREE | | | 22c. DATE SIGNED
9/12/85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER J. ALT, M.D. | | | 22e. ADDRESS
301 MARYGOLL RD
BALTIMORE, MD 21229 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
G. Truman Schwab | | | 3151 BALTO. NAT'L
PIKE # 21229 | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
ne Davidson-Randall | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)

item 16b, film#G607-

FOR
1- STATE
REGISTRAR 9-30-85jlbSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 5 0 6

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OF PRINT) LORETTA H. SCHOTT | | | 2a. DATE OF DEATH
MONTH DAY YEAR 09-21-85 | | | 2b. HOUR
4:00am | | | |
| 1. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR 05-20-28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 12. CITY OR TOWN OF DEATH
Baltimore, Md. | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2749 Pelham Ave Balto, Md 21213 | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 15. KIND OF BUSINESS OR INDUSTRY
- | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE Maryland 16b. COUNTY - 16c. CITY OR TOWN Baltimore 16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 16e. STREET ADDRESS / ZIP CODE 2749 Pelham Ave - 21213 | | | | | | | | | |
| 17. FATHER'S NAME
FIRST MIDDLE LAST
Anthony - Raymond | | | | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine Buccheri | | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) 212-26-2422 | | | | | 20. INFORMANT
ADDRESS
Anthony Schott (husband) same address | | | | |
| 21. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia's
DUE TO, OR AS A CONSEQUENCE OF (c) myocardial infarct | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min.
2 yrs.
2/14/68 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 22a. DATE OF OPERATION | | | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 22c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 23b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 24a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 24b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 24c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 25. I certify that (I) (this hospital) attended the deceased from 2/16 19 68 , to 9/21/85 19 - , that (I) viewed last saw the deceased alive on 9/19/85 19 - , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) viewed did not view the body after death. | | | | | | | | | |
| 26. SIGNATURE
Alan B Cohen DEGREE MD | | | | | | 26a. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 26b. DATE SIGNED
9/23/85 | |
| 27. PHYSICIAN'S NAME (TYPE OR PRINT)
Alan B. Cohen | | | | | | 27a. ADDRESS
201 E Univ Park. Balt Md 21218 | | | |
| 28a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 28b. DATE
9/24/85 | | 28c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 28d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | |
| 29. FUNERAL HOME
NAME SCHTMUNEK FUNERAL HOME, INC. ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | | | | | | 30. DATE REC'D. BY REGISTRAR SEP 24 1985 REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be attached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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W:00am

02-11-55

02-11-55

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM G. SCHULTHEIS | | | 2a. DATE OF DEATH
MONTH 9 DAY 24 YEAR 85 | | 2b. HOUR
8:23 P. M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH May DAY 03 YEAR 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electronics | | 12b. KIND OF BUSINESS OR INDUSTRY
Fed. Employee |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. CITY OR TOWN Baltimore 13c. CITY OR TOWN Arbutus | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7145 Waterloo Road 21227 |
| 14. FATHER'S NAME
FIRST Walter MIDDLE D. LAST Schultheis | | | 15. MOTHER'S MAIDEN NAME
FIRST Mildred MIDDLE E. LAST Gray | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT
ADDRESS
Frances Schultheis 7145 Waterloo Road 21227 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular tachycardia | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) cardiac arrest with cardiogenic shock | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) congestive heart failure | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **a**

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT. 23, 1985 to SEPT. 24, 1985 , that (I) (we) last saw the deceased alive on SEPT. 24, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | |
| 22b. SIGNATURE
M. Keith Rawlings | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
9/24/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. KEITH RAWLINGS, M.D. | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | |

| | | | |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
09-27-85 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY STATE Maryland |
| 24. FUNERAL DIRECTOR
NAME HUBBARD FUNERAL HOME, INC. ADDRESS 4107 WILKENS AVENUE | | 25a. DATE REC'D. BY REGISTRAR
SEP 27 1985 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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28-10-87

20% COTTON BLECK 27



WINTER 1987

276114

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 5 0 8

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
IDA SCHWARTZ | | | 2a DATE OF DEATH
MONTH DAY YEAR
09 27 85 | | | 2b HOUR
5 ¹⁰ A M | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
01 14 19 | | 6 AGE (IN YEARS LAST BIRTHDAY)
66 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10 CITY OR TOWN OF DEATH
Balt | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSP of Baltimore | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
MD | | 13b COUNTY
Balt | | 13c CITY OR TOWN
BALTIMORE | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
BENJAMIN | | 15 MOTHER'S MAIDEN NAME
SARAH GOLDSMITH | | 16 WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE WAR OR DATES)
NO | | | |
| 17 INFORMANT
MARTIN SCHWARTZ | | 18 8050 MILTON AVE. BALTO., MD 21207 | | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Renal Failure, Anemia, Infection, Coronary Artery Dis.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from July 25, 1985, to Sept 27, 1985, that (I) (we) last saw the deceased alive on July 27, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
Laurence B. Marks MD | | DEGREE | | 22c DATE SIGNED
9/27/85 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
LAURENCE B. MARKS | | 22e ADDRESS
6014 A Green Meadow Pkwy Balt 21209 | | | | | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b DATE
SEPT. 29, 1985 | | 23c NAME OF CEMETERY OR CREMATORY
BETH EL MEM. PARK | | 23d LOCATION
CITY OR TOWN COUNTY STATE
RANDALLSTOWN BALTO. MD | |
| 24 FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25 DATE REC'D. BY REGISTRAR 10/1/85 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers: pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a coroner must be notified at once.

BP



281014

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 0 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|--|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST: <u>Stella</u> MIDDLE: <u>PX</u> LAST: <u>Schwarz</u> | | | 2a. DATE OF DEATH
MONTH: <u>9</u> DAY: <u>28</u> YEAR: <u>85</u> | | 2b. HOUR
<u>9:25 PM</u> | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH: <u>12</u> DAY: <u>12</u> YEAR: <u>1911</u> | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<u>73</u> YRS. | | IF UNDER 1 YEAR
MONTHS: <u>7</u> DAYS: <u>22</u> | | IF UNDER 24 HRS.
HOURS: <u>9</u> MIN: <u>25</u> | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>SINAI HOSPITAL</u> | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>MERCHANT</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>RETAIL</u> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<u>MD</u> | | 13b. COUNTY
<u>BALTIMORE</u> | | 13c. CITY OR TOWN
<u>BALTIMORE</u> | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS ZIP CODE
<u>2500 Belvedere Avenue</u> <u>21215</u> | | | | |
| 14. FATHER'S NAME
FIRST: <u>MEYER</u> MIDDLE: LAST: <u>LUBMAN</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST: <u>IDA</u> MIDDLE: LAST: <u>SANDLER</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
<u>XXXXXXXXXX</u> | | 16b. SOCIAL SECURITY NO.
<u>003-35-7660</u> | | 17. INFORMANT
<u>ALAN KRITT</u> ADDRESS: <u>APT. 4C</u> | | |
| 17. INFORMANT
<u>222 MID PINE CT. OWINGS MILLS, MD 21117</u> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Tracheal Mass</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. _____ | | | | | | |
| MEDICAL CERTIFICATION | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 26</u> 19 <u>85</u> to <u>Sept 28</u> 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>Sept 28</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>D. Kelly MD</u> | | | | 22c. DATE SIGNED
<u>9/28/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>D Kelly MD</u> | | | | 22e. ADDRESS
<u>Sinai Hospital</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>BURIAL</u> | | 23b. DATE
<u>OCT. 2, 1985</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>SHAAREI ZION</u> | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>ROSEDALE BALTO. MD</u> | | 24. FUNERAL DIRECTOR
NAME: <u>SOL LEVINSON & BROS., INC.</u>
ADDRESS: <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u> | | | | |
| 25a. DATE REC'D. BY REGISTRAR
<u>OCT 4 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be located at once.

BP

Handwritten notes on lined paper, including the word "TABLE" at the top left and "TABLE" at the bottom left. The text is mostly illegible due to fading and bleed-through.



282018

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM NUMBER 11.9 PER.PH.CALL

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 1 0

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GRACE SCOTT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 29, 1985 | | 2b. HOUR
11:38AM | | | | | | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 10 06 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 72 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOME HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
541 N. Carrollton Ave. 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Scott | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Henson (Scott) | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
Betty Price 2402 Loch Raven Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) CANCER OF LUNG
DUE TO, OR AS A CONSEQUENCE OF
(c) SEVERE ANEMIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 13, 1985 to SEPTEMBER 29, 1985 that (I) (we) last saw the deceased alive on SEPTEMBER 29, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Mukesh Luhar</i> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
SEP 29 1985 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MUKESH LUHAR, MD. | | | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MD. 21231 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
10-3-85 | | 23c. NAME OF CEMETERY OR CREMATORY
ZION | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
W.C. MARCH F/H CO. | | | | | | ADDRESS
1101 E. NORHT Ave. | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Henson</i> | | | |

SPS018



20% COTTON FIBER

BOND

MINIATURE

266034

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 5 1 1

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Marion R Scott | | | 2a. DATE OF DEATH
MONTH 9 DAY 13 YEAR 85 2b. HOUR 3:50 P.M. | | |
| 3. SEX
M | 4. RACE
Black | 5. DATE OF BIRTH
MONTH 9 DAY 16 YEAR 22 | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GEORGIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DEATON MEDICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
611 S. Charles Street 21230 | |
| 14. FATHER'S NAME
FIRST ROBERT MIDDLE SCOTT LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN MIDDLE LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
214-12-1663 | 17. INFORMANT
MARION R. SCOTT JR. 1624 ABBOTSTON | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of bladder with metastases
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
485 | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 4/19 19 85 to 9/13 19 85 that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Alfred J. Damm MD | | | DEGREE
 | 22c. DATE SIGNED
9/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9-20-85 | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW CEMETERY | | 23d. LOCATION
CITY OR TOWN BALTIMORE STATE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME Wm. C. Morrell ADDRESS 1101 E North Ave | | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1985 25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and examined and approved by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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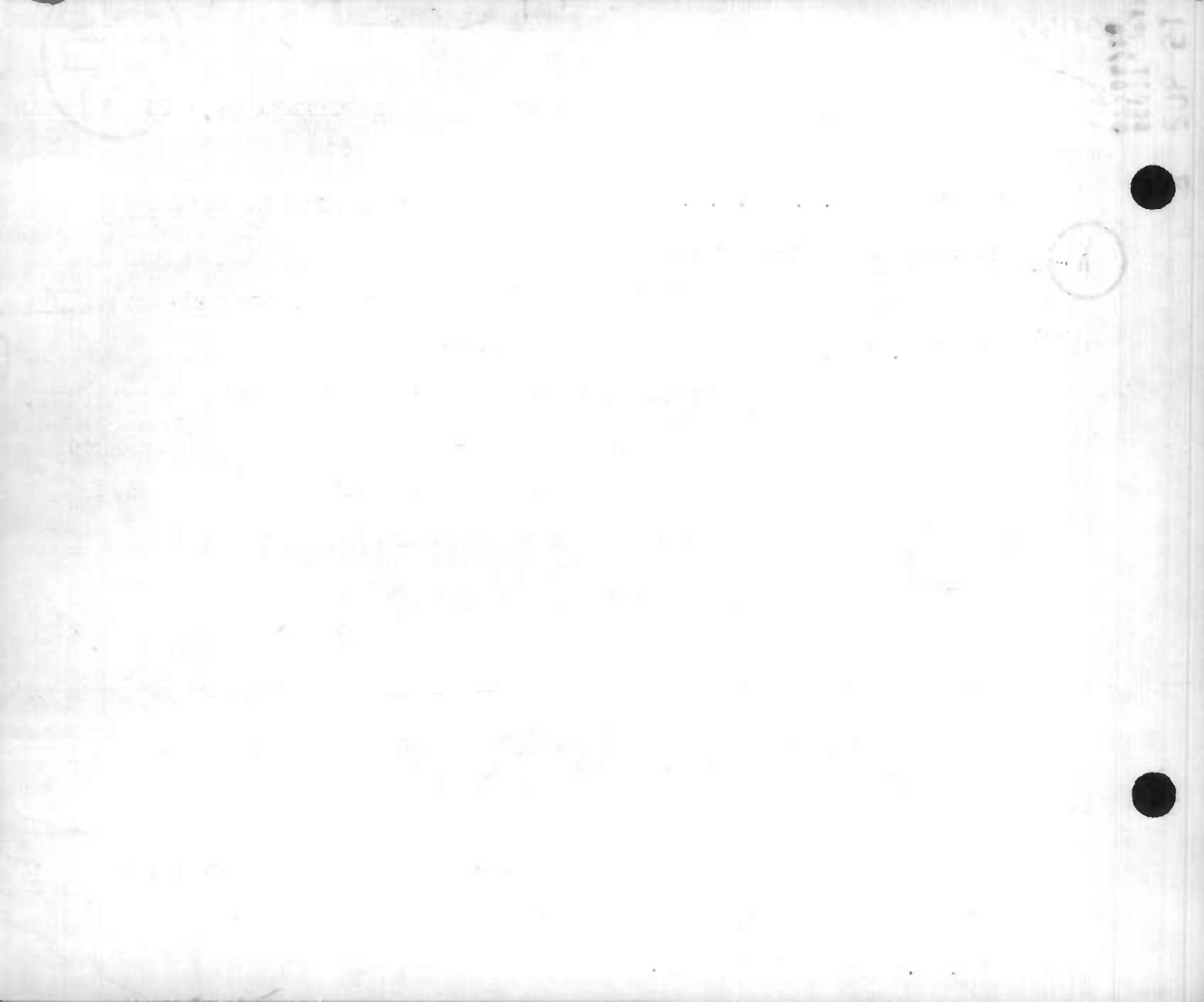
20% COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE E. LAST SCOTT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 06 1985 | | | 2b. HOUR
10:55AM | |
| 3. SEX
FEMALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH 7 DAY 6 YEAR 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57
YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
WASHINGTON D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
504 E. 23rd STREET 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEROY T. QUEEN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY BEAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
579- 30-1361 | | 17. INFORMANT
ADDRESS
SANDRA V. ALLISON 3750 LYNDALE AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Progressive renal insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Stage IV metastatic Ovarian Ca.</u> | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes | |
| | | | | | | days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Atrial fibrillation, No heart failure, inability to tolerate PO</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> , 19 <u>85</u> , to <u>9/6</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>Sept 6</u> , 19 <u>85</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>cBaill</u> | | | | DEGREE | | 22c. DATE SIGNED
<u>9/6/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>BAILL, CORI</u> | | | | 22e. ADDRESS
<u>600 N. Wolfe St. Balt Md. 21205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEMORIAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARBUTUS MARYALND | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | |

BP



268030

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Sharey Lenore SCOTT | | 2a. DATE OF DEATH MONTH DAY YEAR
SEPTEMBER 12, 1985 | | 2b. HOUR
03:56PM | |
| 3. SEX
Female | | 4. RACE
Col 2 | | 5. DATE OF BIRTH MONTH DAY YEAR
9/12/85 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
— | | 7a. BIRTHPLACE (STATE OR FOREIGN)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
BABY | |
| 11. CITY OR TOWN OF DEATH
BALTIMORE | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 13. KIND OF BUSINESS OR INDUSTRY | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 15. FATHER'S NAME FIRST MIDDLE LAST
William Scott | | 16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Valencia A. Scott | | 17. STREET ADDRESS ZIP CODE
5870 Stephen Forest rd 21045 | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 18b. SOCIAL SECURITY NO.
NONE | | 19. INFORMANT ADDRESS
Mrs VALENCIA SCOTT 5870 Stephen Forest Rd 21045 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) multiple congenital malformations
DUE TO, OR AS A CONSEQUENCE OF
(c) holoprosencephaly
Approximate interval between onset and death: 10 minutes | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 12th 1985 to Sept 12th 1985 , that (I) (we) lost saw the deceased alive on Sept 12th 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. M. Rasmussen MD | | DEGREE | | 22c. DATE SIGNED
9/12/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. M. Rasmussen | | 22e. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | 22f. DATE REC'D BY REGISTRAR 22g. REGISTRAR'S SIGNATURE
SEP 23 1985 John Davidson-Randall | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Hosp. | | 23b. DATE
9/19/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Guilford Bapt. Ch. Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY
Howard Co. Md | | 23e. DATE REC'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
SEP 23 1985 John Davidson-Randall | | 23g. DATE REC'D BY REGISTRAR 23h. REGISTRAR'S SIGNATURE
SEP 23 1985 John Davidson-Randall | |
| 24. FUNERAL DIRECTOR NAME
Joseph C. Rasmussen | | 24. FUNERAL DIRECTOR ADDRESS
2222 W. York Ave | | 24. FUNERAL DIRECTOR ADDRESS
2222 W. York Ave | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by a medical physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place will be taken by pages 4 and 5 which are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.



280066

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25514
REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------|--|--|--|--|--|---|--|---|--|---|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9 29 1985 | | | | | | | | | | 7b. HOUR 12:50 M | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
WHITEFIELD SCOTT | | | | | | | | | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 29 1985 | | | | | | | | | | 7d. HOUR 12:50 M | | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 7 31 22 63 | | 6. AGE (IN YEARS BIRTHDAY) MONTHS DAYS HOURS MIN. YRS. | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Charlotte Co. VA. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 10. CITY OR TOWN OF DEATH
Baltimore | | | | | | | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2704 Reisterstown Rd. | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3627 LIBERTY HGTS AVE. 21216 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
HERBERT SCOTT | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY WHITE | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
YES | | | | | | | | | | 16b. SOCIAL SECURITY NO.
WW 11 231-12-2392 | | 17. INFORMANT ADDRESS
CLAUDIA SCOTT | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8880 IMMEDIATE CAUSE (a) Acute subdural hematoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Alcoholism | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. HOUR A.M. MONTH DAY YEAR
? P.M. 9-29- 1985 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject apparently fell & struck head. | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
? | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
? Head only | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Ann M. Dixon</i> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED
9-30-85 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
10-4-85 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. DOUGLAS CEM. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
CHARLOTTE CO., VA. | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
LEROY O. DYETT 4600 LIBERTY HGTS AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Gelia...</i> | | | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, SETTING PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

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20% COTTON YARN

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|---|--|---------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William Scott | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 7, 1985 | | 2b. HOUR
MIN.
5:30 P.M. | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 23 26 | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
59 | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDDIE SCOTT | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DELIA SCOTT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | 16b. SOCIAL SECURITY NO.
217-12-9369 | | 17. INFORMANT
ADDRESS
ALMA G. SCOTT 205 SPRING COURT | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory Arrest minutes
DUE TO, OR AS A CONSEQUENCE OF
(b) Brain Metastasis months
DUE TO, OR AS A CONSEQUENCE OF
(c) small cell carcinoma of Penis 1 1/2 years | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (X) (this hospital) attended the deceased from August 29 19 85 to September 7 19 85 that (X) (we) last saw the deceased alive on September 7 19 85 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>Michael Rossini, Jr.</i> DEGREE | | | | 22c. DATE SIGNED
9/9/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL ROSSINI, JR., M.D. | | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS MARYLAND | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 11 1985 | | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | |

DIVISION OF VITAL RECORDS, 701 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to advise.

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269017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 1 6

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
KATHLEEN J SCRIVEN | | | | 2a. DATE OF DEATH MONTH DAY YEAR
9-22-85 | | | | 2b. HOUR
12:45 PM | |
| 3 SEX
F | | 4 RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
09-02-12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Medical | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Timonium | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Walter Scriven | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ella M. Trumbo | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
220 24 4491 | | 17. INFORMANT ADDRESS
Hugh F. Coyle 13 Scottsdale Ct.
Timonium, Maryland 21093 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BREAST CA
DUE TO, OR AS A CONSEQUENCE OF
(b) LIVER METASTASIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Tullio Emanuele MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9-22-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TULLIO EMANUELE | | | | | | 22e. ADDRESS
GS H 5601 LOCH RAVEN Bv | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Sept. 25, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION
CITY OR TOWN COUNTY
Timonium, Baltimore Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | | | 6500 York Rd.
ADDRESS | | 25a. DATE REC'D BY REGISTRAR
SEP 24 1985 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

538017

9-23-88

DRIVEN

KATHLEEN T

9-23-88

W

E



BRAND

METASTATIC



NON
FIBROS

9-23-88

Public Services, MD

9-23-88

THURIC EMANUELE G H

259190

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
Robert M. Sears | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR MIN
11:15 A.M. | |
| 3 SEX
MALE | | 4 RACE
NEGRO | | 5 DATE OF BIRTH MONTH DAY YEAR
10 2 1878 | | 6 AGE (IN YEARS LAST BIRTHDAY)
106 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GEN | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YRS)
FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
md. | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
THOMAS SEARS | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SUSAN ADAMS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | |
| 17 INFORMANT
EMMETT J. SEARS | | ADDRESS
S/A | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>generalized arteriosclerosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>85</u> , to <u>9/11</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Marcos B. Galicia | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/11/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCOS B. GALICIA M.D. | | 22e. ADDRESS
North Charles GEN. Hospital | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
9/15/85 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Bapt. Union Ch. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
D.I./Wyn. VA. | | 24 FUNERAL DIRECTOR
NAME
CHATHAM HARRIS | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Ch Davidson-Randall | | | | | | | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

259149

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|--|---|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) Max Seidman | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 - 10 - 85 | | | 2b. HOUR
6 59/AM | | | |
| 3. SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 7, 1912 | | 6 AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
N. CHARLES GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PROPRIETOR | | 12b. KIND OF BUSINESS OR INDUSTRY
GEN. MDSE. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6820 CHEROKEE DR. #21209 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MORRIS SEIDEN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LEAH SEAMAN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | | | |
| 17 INFORMANT MRS. BLANCHE SEIDMAN
6820 CHEROKEE DR. BALTO., MD 21209 | | | | | | | | | |

| | | | |
|---|--|---|--|
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic Coronary Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 32 years | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
7 hours | |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Diabetes mellitus

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (the hospital) attended the deceased from **January 15, 1981** to **September 10, 1985**, that (I) (we) last saw the deceased alive on **September 10, 1985**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|--|--|---|--|--|--|
| 22b. SIGNATURE
Henry I. Babitt, M.D. | | DEGREE | | 22c. DATE SIGNED
September 10, 1985 | |
| 22d. PHYSICIAN'S NAME
(TYPE OR PRINT)
Henry I. Babitt, M.D. | | 22e. ADDRESS
2724 North Charles St Balto, Md. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |

| | | | | | | | |
|--|--|------------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
SEPT. 11, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
MOGAN ABRAHAM | | 23d. LOCATION
ROSEDALE BALTO. MD | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randell | |
| NAME
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | ADDRESS | | | |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and so long as it is filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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262121

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 3 1 9
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) OSCAR L. SEILAND | | | 2a DATE OF DEATH MONTH DAY YEAR
September 13, 1985 | | | 2b HOUR
5:00 P.M. | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
Nov. 28, 1904 | | 6 AGE (IN YEARS - 1st BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7c CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary Treasury | | 12b KIND OF BUSINESS OR INDUSTRY
Local 426 | | |
| 13a STATE
Md. | | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
6202 Marietta Avenue 21214 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John O. Seiland | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Aas | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17 INFORMANT
ADDRESS
Mrs. Helen R. Seiland Same | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 13, 19 85 to SEPT 13, 19 85 , that (I) (we) lost
saw the deceased alive on not appl. 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Ranjiv Saini MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
9/13/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RANJIV SAINI M.D. | | | | | | 22e. ADDRESS
GOOD SAMARITAN HOSP. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Sept. 17, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Belair Memorial Gdns. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Belair Harford Md. | | | |
| 24 FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
Gilda Anderson | | |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR A Dying PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

101585

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25520
REG. NO.

268008

| | | | | | |
|--|--|---|---|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| Lisa B. Sellman | | 9 7 19 85 | | 12:50 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Female | Black | 9/11/51 | 33 YRS. | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | NEVER MARRIED | WIDOWED | DIVORCED |
| Md. | USA | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | | Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | 2224 Walbrook Avenue | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Md. | | Balto. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2224 Walbrook Ave. 21216 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | |
| Walter Sellman | | | Ernestine Sellman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| (YES, NO, OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | Ernestine Sellman 2224 Walbrook Ave Q(16) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a): Fatty Liver | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| (b): | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c): | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Thomas D. Smith, M.D. | | Acting Chief | | 9/8/85 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Thomas D. Smith, M.D. | | 111 Penn St. Balto.MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9-11-85 | | Mt. Zion Cem. | |
| 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Lansdown, A.C. Md. | | SEP 23 1985 | | Julia Anderson Gendall | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | |
| Charles A. Rice FSPA 1300 Eutaw Pl | | | SEP 23 1985 | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

200335



U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the medical examiner, it should be detached for use as the burial-transit permit. Then please remove the date of death and the cause of death and return it to the State Dept. of Health and Mental Hygiene prior to burial. (If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR reb 9/25/85 item 16b corrected per F.H. | | | | | | | | | |
| 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ERNEST SINCLAIR SENIOR | | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
COL 2 | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEP 14, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | 7. DATE OF DEATH MONTH DAY YEAR
SEPTEMBER 19, 1985 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
AUTO | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2910 KLOIN AVE 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
LEON SENIOR | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
KATIE RICH | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO.
220038545 | | 17. INFORMANT ADDRESS
Mrs Phoebe Senior 2910 KLOIN AVE 21216 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 minutes | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4:10 AM 9-19, 1985 to 4:37 AM 9-19, 1985, that (I) (we) last saw the deceased alive on 9-19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Mark C. Benjunes | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
9-19-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark C. Benjunes | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(BY) BURIAL | | 23b. DATE
9-23-85 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBURUS MEM PLE | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO, CO MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JOSEPH L. RUBS 3222 W. NORTH AVE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Rendell | | | |

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NOTICE

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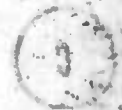
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed in the 102 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|---|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BETTY SMITH SESSOMS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 19, 1985 | | | 2b. HOUR
A M
11:45 | |
| 3 SEX
FEMALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 3 50 | | 6 AGE (IN YEARS LAST BIRTHDAY)
34 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
BEST MOTELS | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MARYLAND 13b COUNTY WORCESTER 13c CITY OR TOWN BERLIN | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Route #4, Box 156 / 21811 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Smith | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-52-0103 | | 17. INFORMANT
Jame Sessoms | | | ADDRESS
Same as Above | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Disease | | | | | | | | | months |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Cervical Carcinoma | | | | | | | | | years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Small and large bowel obstructions, 2° to tw more erosion | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 21st, 19 85 to September 14th, 19 85, that (I) (we) last saw the deceased alive on September 14th, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J. Cori Baill | | | | | DEGREE | | 22c. DATE SIGNED
9/19/85 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
I. CORI BAILL | | | | | 22e. ADDRESS
The Johns Hopkins Hospital Balt. Md. 21205 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(METHOD)
BURIAL | | | 23b. DATE
9/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
EVERGREEN Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Berlin Worcester Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Jolley Memorial Chapel | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 1 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 5 2 3
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LILLIAN SHANK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-14-85 | | 2b. HOUR
4:35 AM | |
| 3 SEX
Female | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-16-15 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
69 | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bay Secours Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
M.D. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1214 Eutaw Key Circle Hosp. place, Balto 21217 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anderson Brown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
900-39-5740 | | 17. INFORMANT
ADDRESS
Bernard Smith 3544 Rock Creek Washington D.C. RD | | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Cardio-respiratory arrest.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Cerebro-vascular accident**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Arterio-sclerotic hypertension.**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Volvolus, cecum.

| | | | | | |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION
7-22-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cecal volvulus & gangrene. | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 7-21-85 to 9-14-85 that (A) (we) last saw the deceased alive on 9-14-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. Zaldivondo | | | | 22c. DATE SIGNED
9/17/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. ZALDIVONDO | | | | 22e. ADDRESS | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
9/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chas. A. Rice FSPA 1300 Eutaw PL. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon adapters. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

249116

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Lillian W. Sheckels</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9-3-85</i> | | 2b. HOUR
<i>10 45 AM</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>02 24 92</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY))
<i>93</i> YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Queenstown, Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>City Balto.</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Deacon Med. Center, Balto.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
<i>21230</i> | | 13a. STREET ADDRESS
<i>1105 W. Ostend St. Balto. Md.</i> | | | | | | |
| 13b. STATE
<i>Maryland</i> | | 13c. COUNTY
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>1105 W. Ostend St. Balto. Md.</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>James E. Brown</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Mabel Dean</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>213-77-3115</i> | | 17. INFORMANT
ADDRESS
<i>Daughter - Eleanor Kozma 1 W. Conway St. City 21201</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cancer of bladder</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>4 months</i> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>week</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that the (this hospital) attended the deceased from <i>9/3</i> 19 <i>85</i> to <i>9/3</i> 19 <i>85</i> , that we (we) last saw the deceased alive on <i>9/3</i> 19 <i>85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, that (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. Gladue, MD</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>9/9/85</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Sept. 6, 1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>London Park Cemt.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Maryland</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>McCully Funeral Home, 130 E. Fort Ave.</i> | | | | 24b. DATE RECD. BY REGISTRAR
<i>SEP 4 1985</i> | | | | |
| 24c. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | 24d. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
CHARLES H. SHEETZ, JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-6-85 | | 2b. HOUR
3:35 AM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
03-28-14 | 6. AGE (IN YEARS (LAST BIRTHDAY))
71 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. Virginia | 8b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
224 HOMEWOOD TERRACE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dentist | 12b. KIND OF BUSINESS OR INDUSTRY
Dentistry | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE
224 HOMEWOOD TERRACE 21218 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES HARRY SHEETZ, SR | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANITA READ | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | 17. INFORMANT
ADDRESS
Thelma Sheetz 224 HOMEWOOD TERRACE 21218 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Probable Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>metabolic encephalopathy</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 week</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus, Diabetic Cardiomyopathy, severe peripheral & cerebral vascular disease</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>October</u> , 19 <u>84</u> , to <u>9/6</u> , 19 <u>85</u> , that (2) (we) last saw the deceased alive on <u>9/3</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Alicia Cool-Foley</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
<u>9/6/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. ALICIA COOL-FOLEY | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
09-06-85 | 23c. NAME OF CEMETERY OR CREMATORY
SECURITY PROCESS | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CATONSVILLE BALTIMORE MD. | | |
| 24. FUNERAL DIRECTOR
NAME
HUEBARD FUNERAL HOME, INC. | | ADDRESS
21229
4107 WILKENS AVENUE | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury or other traumatic event, the medical examiner must be notified above.

254004



LIBER

20% COTTON

WILKINSON



Ballant

253128

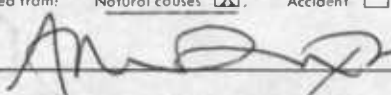
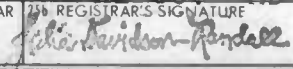
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 2 5 5 2 6
 REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|------------------|--|---|--|---|--|--|--|--|--|------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
JESSIE | | MIDDLE | | LAST
SHELTON | | 2a. DATE KNOWN OF DEATH | | MONTH
9 | | DAY
5 | | YEAR
19 85 | | 2b. HOUR
M | | | | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH
5 DAY
8 YEAR
28 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
57 YRS. | | IF UNDER 1 YR.
MONTHS
DAYS
HOURS
MIN | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
MONTH
9 DAY
5 YEAR
19 85 | | 2d. HOUR
12:31
A M | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Key Medical Center | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1903 E. 32nd STREET 21218 | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST
UNKNOWN | | | | MIDDLE | | | | LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST
UNKNOWN | | | | MIDDLE | | | | LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO.
418-36-5567 | | | | 17. INFORMANT
ADDRESS
MARTHA BRISBON 1903 E. 32nd ST. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED
9-5-85 | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
9/9/85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | | | 23d. LOCATION
CITY OR TOWN
ANNE ARUNDAL CO. MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | ADDRESS
1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 6 1985 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 2 7

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JEREMY MICHAEL SHOCKNEY | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 22 85
12b. HOUR
1:30 PM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 22 85 | | 6. AGE (IN YEARS LAST BIRTHDAY)
3 hrs. YRS MONTHS DAYS HOURS MIN.
2 30 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
----- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
Charles M. Shockney, Jr. | | | | 15. MOTHER'S MAIDEN NAME
Nancy Lynn Dawson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
Charles M. Shockney 1014 Howland Square 21227 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PREVENTABLE
DUE TO, OR AS A CONSEQUENCE OF
(b) EXTREME PREMATUREITY
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ABRUPTIO PLACENTAE | | | | | | | |
| 19a. DATE OF OPERATION
N Gu | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 22 85, to 9 22 85, that (I) (we) last saw the deceased alive on 9 22 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
M. H. A. L. RABBAI | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9 22 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. H. A. L. RABBAI | | | | 22e. ADDRESS
NICU MERCY HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 25 1985 | | 25b. REGISTRAR'S SIGNATURE
John B. ... | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's file. It should be detached for use as the burial transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOTICE



273050

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be signed by the attending physician and completely filled out within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 by the funeral director, page 4 by the funeral director.

IMPORTANT: If item 21 is marked on item 18 there is only injury, or other traumatic event, the medical examiner should be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 2 8

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LARRY BRIAN SHODA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 19 1985 | | | 2b. HOUR
05:30 | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 30 1956 | | 6. AGE (IN YEARS LAST BIRTHDAY)
28 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LAWYER | | 12b. KIND OF BUSINESS OR INDUSTRY
LITIGATION | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
HOWARD | | 13c. CITY OR TOWN
ELLICOTT CITY | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10121 MAPLEWOOD DRIVE 21043 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALTON A. SHODA | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DELORES ROSE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
216/72/3574 | | 17. INFORMANT
ALTON A. SHODA | | 17. ADDRESS
10121 MAPLEWOOD DRIVE
ELLICOTT CITY, MD 21043 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PROBABLY HYPERCHOLESTEROLIA + INANITION
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC MALIGNANT MELANOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 WKS
3 MONTHS | | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION
85-06-21 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
LYMPH NODE BIOPSY FOR DIAGNOSIS | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG 1 , 19 85 , to SEPT 19 , 19 85 , that (I) (we) last saw the deceased alive on SEPT 19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Brian J. Ward | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
85-09-19 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRIAN J. WARD | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL #16767 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
21 SEPT 85 | | 23c. NAME OF CEMETERY OR CREMATORY
CRESTLAWN MEM. GDN. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MARRIOTTSTVILLE HOWARD MD | | | |
| 24. FUNERAL DIRECTOR
NAME
SLACK FUNERAL HOME | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
SEP 26 1985 | | | | | |

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D. FRANK, ADAMS
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VIA
F/A

DEC 28 1982

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 8525529 | | | | | | | |
| 1. DECEASED NAME (FIRST MIDDLE LAST)
NATHAN R. SHORTER | | | | 2a. DATE OF DEATH (MONTH DAY YEAR)
9/27/85 | | 2b. HOUR
9:15 PM | | | |
| 3 SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH (MONTH DAY YEAR)
7 11 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | 7. UNDER 1 YEAR (MONTHS DAYS WEEKS HOURS)
YES | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
A.C.O. MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Forklift operator | | 12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. STREET ADDRESS / ZIP CODE
3005 LAWYER RD 21216 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)
ROBERT SHORTER | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
JANIS SMITH | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
717-07-6561 | | 17. INFORMANT ADDRESS
Gloria Greenwood 7109 Fairfax Rd | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE MI</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE GI BLEED</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ACUTE RENAL FAILURE, D.I.C.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
53 min
53 min
UNKNOWN | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
MARCIA V. BROCK | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
9/27/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCIA V. BROCK | | | | 22e. ADDRESS
Sinai Hospital of Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10/3/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Vernon | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lanham, MD | | | |
| 24. FUNERAL DIRECTOR
M. A. Brock | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | 25b. REGISTRAR'S SIGNATURE
M. A. Brock | | | |

1917



268017

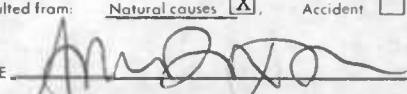
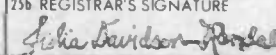
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN AUTOPSY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP _____
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 5 3 0
REG. NO.

| | | | | |
|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
SIDNEY Joseph SHOWS | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
9 18 19 85 | | 2b. HOUR
10:10 |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 12 1922 | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Orleans, La. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5105 Harford Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Correction Officer | |
| 13a. STATE
Maryland | | 13b. COUNTY
Balt. City | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Sidney Shows | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bernadine Cyrus | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
438-12-5633 | | 17. INFORMANT
Denise Shows |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
9-19-85 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St., Balto., MD 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-21-85 | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Mem. Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Finksburg Carroll Md. |
| 24. FUNERAL DIRECTOR
NAME
Thomas D. Fletcher & Son | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
 |

254 East Main Street
Westminster, Md. 21157

179835

268110

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|--|--|-------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
THADDEUS S. SIENKIEWICZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 18, 1985 | | 2b. HOUR
9 PM | |
| 3. SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 17 11 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
74 MONTHS 11 DAYS | | 8. IF UNDER 74 HRS
HOURS MIN.
10 HOURS 00 MIN. | | |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Postal Clerk | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Maryland | | 13b COUNTY
Baltimore | | |
| 13c. CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
3601 Glenmore Ave. 21214 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vincent Sienkiewicz | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Feliksa Potrzuski | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b SOCIAL SECURITY NO.
217-07-2307 | | 17 INFORMANT
ADDRESS
Mrs. Libby Sienkiewicz Same as # 13e | | 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac Vascular Disease - I. Coronary Insufficiency.
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetes Mellitus - Type 1
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus - Type 1 | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 15 Dec 72 19 82 , to 18 Sept 85 19 85 , that (I) (we) last saw the deceased alive on 18 Sept 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE
John C. Hyle MD | | |
| 22c. DATE SIGNED
9-19-85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John C. Hyle, M.D. | | 22e. ADDRESS
7527 Belair Rd. Balt 21236 Md | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9-21-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc. Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | |
| 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | 26. HOSPITAL OR ATTENDING PHYSICIAN (The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.) | | 27. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted. | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

ADMINISTRATIVE DIVISION

Mr. J. E. Kelly

U.S.A.

Food Commission Building

Washington

1100 Wisconsin Ave. N.W.

Vincent Stenhouse

11-07-54



RECEIVED
OCT 10 1954

John E. Kelly, U.S.A.

2-21-54

Leonard A. Kelly, Inc., Baltimore, Md.

264114

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMM - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25532

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|-------------------------------|--|--------------------------------|--|---------|--|------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH ESTI-
MATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ALMA M. SILER | | | | | | | | 9-15-85 | | 19 | | | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD | | 9-15-85 | | 2d. HOUR | |
| Female | | Black | | 1 22 07 | | 78 YRS. | | | | | | 19 | | | | 8:20A
M | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| North Carolina | | U. S. A | | | | Baltimore City | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 503 Lyndhurst Avenue | | Cook | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | | | Baltimore | | | | | | 503 Lyndhurst St. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Wesley Cheeks | | Rosina | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 241-07-6407 | | Sarah Jackson | | 503 Lyndhurst | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY)
Assistant | | DATE
SIGNED | | 9-15-85 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Gregory R. Kauffman, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 9-20-85 | | Arbutus Memorial Park | | Arbutus Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Bailey-Douglass Funeral Home | | 1348 Calhoun St. | | SEP 18 1985 | | John Davidson | | | | | | | | | | | |

32235

32235

20% COTTON FIBER

WIND

WIND



32235

268001

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

| Film G608 item 12a,b | | | | STATE OF MARYLAND | | | |
|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR 10/4/85 rja | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | |
| CERTIFICATE OF DEATH | | | | REG. NO. 85 25533 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Aaron SILVERTHORN | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 19, 1985 | | 2b. HOUR 7:57 P M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 5 22 11 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Blue Collar | | 12b. KIND OF BUSINESS OR INDUSTRY Sparrows Point | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1100 Bolton St. Apt. 618 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hezeakhia Silverthorn | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Saunders | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 241-01-0837 | | 17. INFORMANT ADDRESS Cora Silverthorn 1100 Bolton Hill Apt. 618 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable recent antero-septal myocardial infarction.
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) Visceral congestion and edema. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 17, 85 to September 19, 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 19, 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Harry E. Nervino, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/20/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry E. Nervino, M.D. | | | | 22e. ADDRESS c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/24/85 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md. | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. ADDRESS 1101 E North Avenue | | | | 25a. DATE REGD. BY REGISTRAR SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

BP

1902

FIBER

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TOP

30%

COL

FIBER

1902

CHINA

263166

Items 18 22a 11/7/85 mtb F#609

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 5 3 4

REG. NO.

| | | | | | | | | | | | |
|--|------------------|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Walata | | MIDDLE
Israel | | LAST
Amde Sion | | 2a. DATE KNOWN OF DEATH
ESTIMATED
9-13-85 | | 2b. HOUR
M | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
10 8 84 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
YRS. 11 | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
9-13-85
19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Trinidad | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5610 Woodmont Ave. Apt. A
21239 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Amde Sion | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jacqueline Hill | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Jacqueline Hill 5610 Woodmont Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Sudden infant death syndrome
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b).
DUE TO, OR AS A CONSEQUENCE OF
(c). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Gregory R. Kauffman, M.D. | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED
9-14-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS
111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
9-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Bailey-Douglass Funeral Home | | ADDRESS
1348 Calhoun St. | | 25a. DATE REC'D. BY REGISTRAR
SEP 17 1985 | | 25b. REGISTRAR'S SIGNATURE
Jana Davidson-Randall | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 18.2. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

BP 1318
DHMH - 17
(VR A15 ME (5))

130% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.



MADE IN U.S.A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 5 3 5
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Bentley, Sidney | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEP 17 '85 | | | 2b. HOUR
9 ¹⁰ AM | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
12-19-1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KESWICK NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
510 MADISON STREET | | 13f. ZIP CODE
21202 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN WRIGHT | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LEAH BUTTS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-22-9848 | | 17. INFORMANT
Dorothy Richardson - Loch Raven Bk | | | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Amyotrophic lateral sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
give rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 30, 1975</u> to <u>September 17, 1985</u> that (I) (we) lost
saw the deceased alive on <u>September 17, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
M. Isabelle MacGregor | | | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. ISABELLE MACGREGOR | | | | 22e. ADDRESS
KESWICK, 700 W. 40th STREET, BALTO MD 21211 | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
9-23-85 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUS MEM. PK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
Brown-Thompson | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 18 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Wilson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

201100



WV 100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

256017

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) CATHERINE A. SKILLMAN | | | 2a. DATE OF DEATH
MONTH September DAY 5 YEAR 1985 | | 2b. HOUR
11:58 M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH 6 YEAR 19 DAY 47 | | 6. AGE (IN YEARS LAST BIRTHDAY)
38 YRS | IF UNDER 1 YEAR
MONTH 11 DAY 11 HOURS 11 MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Never Worked | | 12b. KIND OF BUSINESS OR INDUSTRY
Rosewood Lane |
| 13a. STATE
MD | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Owings Mills | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST Robert MIDDLE Skillman LAST Skillman | | | 15. MOTHER'S MAIDEN NAME
FIRST Marion MIDDLE R LAST Moore | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-76-3359 | | 17. INFORMANT
ADDRESS 21122 Robert E. Skillman 8429 Bay Rd Pasadena, Md | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **presumed Aspiration**

DUE TO, OR AS A CONSEQUENCE OF

(c) **poor swallowing and cough reflex, Cerebral Palsy**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Dissecting Colostomy for Rectal-decubitus fistula

| | | | |
|---|---|--|--|
| 19a. DATE OF OPERATION
9/23/85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Rectal-Sigmoid Decubitus Fistula | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG. 22 , 19 85 , to SEPT 5 , 19 85 that (I) (we) lost
saw the deceased Sept 5 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Thomas J. O'Leary, MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
9/5/85 |
| 22d. PHYSICIAN'S NAME
Thomas J. O'Leary, MD | | 22e. ADDRESS
Univ. Maryland Hosp. 22 S. Green St., Balt. | |

| | | | |
|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | 23b. DATE
9/6/85 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Pk | 23d. LOCATION
CITY OR TOWN Catonsville COUNTY Balto STATE MD |
| 24. FUNERAL DIRECTOR
George J. Gonce | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

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277171

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 5 3 7
CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN H. SKUHR, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 29, 1985 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 21, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1803 Sherwood Avenue Apt. B | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles H. Skuhr | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Schine | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-03-7380 | 17. INFORMANT ADDRESS
Mr. William E. Skuhr 402 Stevenson Lane | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>COPD</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CNF</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Anemia - chronic lower GI bleed</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>10 yr</u>
<u>2 yrs</u>
<u>1 yr</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>g</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>9/19</u> , 19 <u>85</u> , to <u>9/20</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>9/20</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>W E Randall Jr</u> | | | | 22c. DATE SIGNED
9/30/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William E. Randall, Jr. M.D. | | | | 22e. ADDRESS
1205 York Road Lutherville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Oct. 2, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville, Balto., Md.= |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
OCT 2 1985 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>William E. Randall</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

171775

3



OFFICE

20% COTTON FIBER

OFFICE

20% COTTON FIBER

268146

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25538

| | | | | | | | | |
|---|-------------------------|--|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARCELLOUS SLIGHT | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
9 12 1985 | | | 2b. HOUR
5:31 A.M. | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
4 28 16 | 6. AGE (IN YEARS)
LAST BIRTHDAY
69 YRS. | IF UNDER 1 YR.
MONTHS DAYS
0 0 | IF UNDER 24 HRS.
HOURS MIN.
0 0 | 2c. DATE PRONOUNCED DEAD
9 12 1985 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2910 Windsor Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Theatre |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Slight | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Martin | | | 13e. STREET ADDRESS
2910 Windsor Ave. 21216 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | (IF YES, GIVE WAR OR DATES)
WWII | | 16b. SOCIAL SECURITY NO.
218-09-7381 | | 17. INFORMANT
Mr. Hiawatha Generette Balto., Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
Ann M. Dixon | | | TITLE (SPECIFY)
Assistant | | | DATE SIGNED
9-12-85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
9-19-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Bailey-Douglass Funeral Home 1348 N. Calhoun St. | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



WILLIAM
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FEB 19 1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 5 2 5 5 3 9

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|--|--|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
JAMES J. SILK | | | 2a DATE OF DEATH
MONTH DAY YEAR
09 18 85 | | 2b HOUR
M
— |
| 3 SEX
MALE | 4 RACE
CAUC. | 5 DATE OF BIRTH
MONTH DAY YEAR
07 02 08 | 6 AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
— — — — | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2641 HUDSON STREET | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TAX AUDITOR | 12b KIND OF BUSINESS OR INDUSTRY
— | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
MD. | | 13b COUNTY
— | 13c CITY OR TOWN
BALTIMORE | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE
2641 HUDSON ST. 21224 |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
OWEN J. SILK | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET KANE | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
— | 17 INFORMANT ADDRESS
AGNES E. SILK 2641 HUDSON ST. 21224 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ALZHEIMER'S DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(b) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) —
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
CARCINOMA LUNG | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 years |
| 19a DATE OF OPERATION
9/21/85 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
6/21/85 | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE
129 S. Broadway BALTIMORE MD. | |
| 22 I certify that (I) (this hospital) attended the deceased from 9/21/85 to 9/21/85, that (I) (we) lost
saw the deceased alive on 9/21/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not see the body after death) | | | | | |
| 22a SIGNATURE
Irvin B. KAPLAN MD | | DEGREE
— | | 22c DATE SIGNED
9/21/85 | |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT)
IRVIN B. KAPLAN MD | | 22e ADDRESS
129 S. Broadway | | 22f ZIP CODE
21231 | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b DATE
9/21/85 | 23c NAME OF CEMETERY OR CREMATORY
GREENMONT CEM. | 23d LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | 23e DATE REC'D. BY REGISTRAR
SEP 23 1985 | |
| 24 FUNERAL DIRECTOR
NAME
KACZOROWSKI FUNERAL HOME | | ADDRESS
2525 FLEET ST. 21224 | | 25 REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH: 16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|--|--------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
SOFIA M. SLIWA | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09 03 '85
2b. HOUR
M | | | | | |
| 3 SEX
Female | | 4 RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 20 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95
YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
F.S.K. Med. Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tailor | | 12b. KIND OF BUSINESS OR INDUSTRY
Self | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jakub Pieklo | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maryanna Stopa | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-07-6640 | | 17. INFORMANT
Miss. Mary F. Sliwa | | ADDRESS
8555 Boston Avenue Balt.; Md. 21222 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Diabetes Mellitus</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> 19 <u>77</u> , to <u>9/3</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>M. Ooooo</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9-4-85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MORTON C. ORMAN | | | | | 22e. ADDRESS
2936 E. BALTIMORE ST 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
09/06/85 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Dabrowski - 1005 Dundalk Avenue 21224 | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 9 1985 | | | | | |

25b. REGISTRAR'S SIGNATURE
John Dabrowski

326064

09 03 '83

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N. H.

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1890 92

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Canal

Female

Baltimore City

U.S.A.

Female

Self

Tailor

U.S. M. Med. Center

Baltimore

91922

633 Boston Avenue - Baltimore, Md.

airplane

Male

Group

Marriages

Slaves

Andrew

633 Boston Avenue
Baltimore, Md. 21202

210-07-6640 Miss Mary F. Slime

St. Stanislaus

2071A

1001 Lombard Avenue 21204

Baltimore

Hd.

264115

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. MAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 5 4 1
REG. NO.

| | | | | | |
|--|---|---|------------------------|---------------------------------------|--|
| 1- STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE OF DEATH | | 2d. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | M | |
| Wilber Smiley | | 9 17 1985 | | 5 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Female | Black | 5- 21 -39 | 46 YRS. | MONTHS DAYS | HOURS MIN. |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9b. CITIZEN OF WHAT COUNTRY? | 9c. BALTIMORE CITY OR COUNTY OF DEATH | | 9d. BALTIMORE CITY OR COUNTY OF DEATH | |
| Florida | U. S. A. | Baltimore City, | | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Maryland General Hospital | Unemployed | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS | | |
| Maryland | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2206 Eutaw Place 21217 | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| Charles Smiley, JR. | Jo Eddie | 261-54-1747 | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? | 17b. INFORMANT | 17c. ADDRESS | | | |
| No | Lavelda Mayo | 1240 Pearl Leaf Ct. 21202 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| Diabetes & Pulmonary embolus | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? | | | |
| | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION | | | |
| | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Dennis F. Smyth, M.D. | | Assistant | | 9/17/85 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Dennis F. Smyth, M.D. | | 111 Penn St. Balto.MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 9-23-85 | Mason Hill Cemetery | Daytona Beach, Florida | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Bailey-Douglass Funeral Home 1348 N. Calhoun St. | | SEP 18 1985 | | John Davidson | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 5 4 2

REG. NO.

| | | | |
|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Anthony L. Smith</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR HOUR
<i>Sept 28 1985 11:30 AM</i> | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>Black</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Aug. 11, 1971</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
YEARS MONTHS DAYS HOURS MIN.
<i>14</i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Canton, Ohio</i> | 7b. CITIZEN OF WHAT COUNTRY
<i>U.S.A.</i> | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>3602 Denny Ln Rd</i> | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
<i>Child</i> | 12b. KIND OF BUSINESS OR INDUSTRY
— |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. <i>57th</i> | | 13b. COUNTY
— | 13c. CITY OR TOWN
<i>Baltimore</i> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Anderson Smith</i> | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Betty Welch</i> | 13d. STREET ADDRESS
<i>3602 Denny Ln Rd</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | 16b. SOCIAL SECURITY NO.
— | 17. INFORMANT
ADDRESS
<i>Anderson Smith 3602 Denny Ln Rd</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>METASTATIC SARCOMA OF LUNG</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 1/2 YRS.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: — | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>AUGUST 9/1985</i> to <i>SEPTEMBER 1985</i> , that (I) (we) last saw the deceased alive on <i>9/19/85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Francisco J. Barriaga</i> | DEGREE
<i>H.D.</i> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
<i>9/30/85</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>FRANCISCO J. BARRIAGA</i> | 22e. ADDRESS NATIONAL INSTITUTES OF HEALTH
<i>BLDG 10 R13N240, BETHESDA, MD, 20205</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
<i>Burial</i> | 23b. DATE
<i>10-5-85</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Verhatus Mem Pl</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Md.</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Joseph L. Kues</i> | | 25a. DATE REC'D BY REGISTRAR
<i>OCT 7 1985</i> | 25b. REGISTRAR'S SIGNATURE
<i>John Anderson</i> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



277092

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 5 4 3

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CAROLYN SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
09 28 85 | | 2b. HOUR
1:02PM |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
7 15 55 | | 6. AGE (IN YEARS LAST BIRTHDAY)
30 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
North Carlone | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | 13a. STREET ADDRESS / ZIP CODE
1823 N. Gay St. 21202 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vance Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Gardner | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| 17. INFORMANT
Rosa Brown | | | ADDRESS
1715 N. Montford ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ventricular tachycardia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) pressor-dependent hypotension
DUE TO, OR AS A CONSEQUENCE OF
(c) pneumococcal sepsis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr.
3 days
3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (we) (this hospital) attended the deceased from 9/25 , 19 85 , to 9/28 , 19 85 , that (we) (we) last saw the deceased alive on 9/28 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Laura J. Hadad | | DEGREE
MD | | 22c. DATE SIGNED
9/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LAURA J. HADAD MD | | 22e. ADDRESS
200 N. Wolfe St. Balto-MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
10-2-85 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 25a. DATE REC'D. BY REGISTRAR
1 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME
W.C. March F/H Co. | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| ADDRESS
1101 E. North Ave. | | | | | |

343025



WASH DC

NOTED VIA

FILE

REC'D

273054

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Carroll (CANNOL) M. (SMITH)</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9 24 85</i> | | | 2b. HOUR
<i>2:25 A</i> M | | | |
| 3. SEX
<i>M</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>3 21 12</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>73</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE CITY MD</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>BALT</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SINAI</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Truck Driver</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Fleet Transfer</i> | |

| | | | | | | | | |
|--|--|--|---|--|---|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>MD</i> 13b. COUNTY <i>BALT</i> 13c. CITY OR TOWN <i>BALT</i> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>3913 Fairview Ave 21216</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>John Smith</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Julia Butler</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>217-05-1026</i> | | 17. INFORMANT
ADDRESS
<i>Pearl G. Smith 3913 Fairview Ave</i> | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Left Lower Lobe Pneumonia*

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Parkinson's D., Alzheimer's Dx

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/23</i> , 19 <i>85</i> , to <i>9/24</i> , 19 <i>85</i> , that (I) (we) last
saw the deceased alive on <i>9/24</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Mark A. Goldstein MD</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>9/24/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MARK A. GOLDSTEIN, M.D.</i> | | | | 22e. ADDRESS
<i>SINAI HOSP.</i> | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>9/27/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arbutus Memorial Pk</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Arbutus Md</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>William C. March F/H 4300 Wabash Avenue</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>SEP 26 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Lilia Davidson-Randall</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral directory, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death must be certified as above.

MEDICAL CERTIFICATION



287041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 5 4 5

| | | | |
|---|--|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| Christine Marie Smith | | 09 29 85-12:15 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| Female | Black | 12 09 40 | 44 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Maryland | USA | | Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Balt. | John L. Deaton | Domestic | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? |
| Maryland | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 13e. STREET ADDRESS | |
| Lawrence | Mildred | 3624 Belvedere 21215 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
| no | 214-40-2930 | Lawrence Hicks, Jr. | 1824 Ashburton St. Baltimore, Md |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Esophagus</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>alcohol abuse</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 19</u> , 19 <u>85</u> , to <u>Sept 29</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Sept 28</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED |
| <u>Ron Wisl MD</u> | | | 9/29/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | |
| Ron Wisl | J. L. Deaton Med Center | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | Oct. 3, 1985 | Mt. Olive Chr. Cem. | Prince Frederick Calvert Md |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |
| Spencer E. Sewell | | Box 31, Prince Frederick, Md. 7 1985 | |

287011

30% COTTON FIB

CHIEF-TAM



Product: Sewell Box 7, Prince Georges, Va.
Date: 1973, 10, 15, 11:00 AM, Prince Georges, Va.

262110

MEMBER 4, PER. PH. 4, CALL

1. FOR 9-23-85 D.W.
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward W. Smith | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 12, 1985 | | | 2b. HOUR
4 A M | | | | |
| 3. SEX
male | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 18 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
54 YRS | | 7. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
mine, Fla | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lab | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
509 Radnor 21210 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Burdick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | 16b. SOCIAL SECURITY NO.
261-40020 | | 17. INFORMANT
NAME ADDRESS
Edward Smith 509 Radnor Ave 21210 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cancer of the tongue
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 7, 1985 , to September 12, 1985 , that (I) (we) last saw the deceased alive on September 12, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Victoria A. Vanik MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
9/12/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Victoria A. Vanik | | | | | | 22e. ADDRESS
Union Memorial Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9/21/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Zion | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William L. D. C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

1
2

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

SECTION

30% COTTON FIBRE

200 11 130

268128

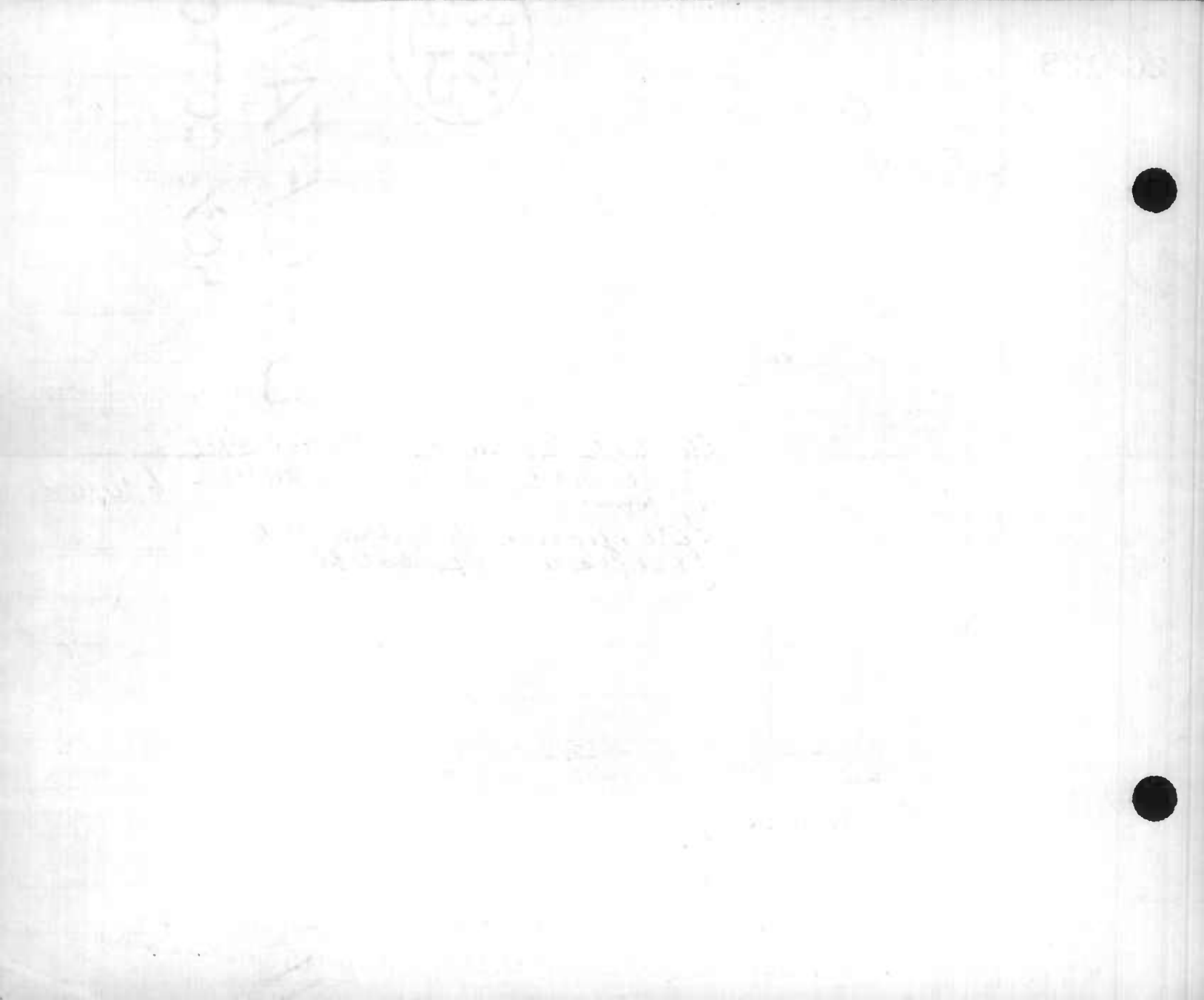
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Gwendolyn J. Smith</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9 23 85</i> | | | 2b. HOUR
<i>10⁴⁰ A.M.</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>4 23 02</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>83</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore city</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>men diam Nursing Center (Hamilton)</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | |
| 13a. STATE
<i>Maryland</i> | | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>John Allen Bushell</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Elizabeth Howell</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>213-38-8330</i> | | 17. INFORMANT
ADDRESS
<i>Mrs. Gwendolyn Newell 3617 Mary Avenue 21206</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Chronic brain syndrome due to cerebral arrest with atrophy of brain.</i>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <i>of brain.</i>
(c) <i>Consequence of rupture of aorta.</i>
DUE TO, OR AS A CONSEQUENCE OF:
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE IMMEDIATE CONDITION GIVEN IN PART I):
<i>gastroenteritis</i> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>6 weeks</i> |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>12/13/84</i> , 19 <i>85</i> , to <i>9/22</i> , 19 <i>85</i> , that (I) (we) lost
saw the deceased alive on <i>8/28</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Ingeborg Fromm</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>9/23/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Ingeborg Fromm, M.D.</i> | | | | 22e. ADDRESS
<i>8014 Old Harford Road</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>9/24/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore Maryland</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Leonard J. Ruck, Inc. 5305 Harford Road 21214</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>SEP 23 1985</i> | | | |

THIS CERTIFICATE MUST BE SIGNED BY THE MEDICAL EXAMINER OR THE REGISTRAR. IF THE MEDICAL EXAMINER IS NOT AVAILABLE, THE REGISTRAR MAY SIGN THIS CERTIFICATE. IF THE REGISTRAR IS NOT AVAILABLE, THE FUNERAL HOME MAY SIGN THIS CERTIFICATE. IF THE FUNERAL HOME IS NOT AVAILABLE, THE DECEASED MAY BE BURIED WITHOUT THIS CERTIFICATE.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



263074

FOR
1- STATE
REGISTRAR

Film G608 item 12a

10/4/85 rja

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 5 4 8

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HAZEL Cdean Smith | | | 2a. DATE OF DEATH
MONTH DAY YEAR 9-13-85 | | | 2b. HOUR
12:46 AM | | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR 10 4 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2817 Rockrose Ave 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Theatrtrick | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary B. mattox | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
217-16-6389 | | 17. INFORMANT
Alfred Howell | | ADDRESS
2817 Rockrose Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Uremia
DUE TO, OR AS A CONSEQUENCE OF
(b) Renal Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypotension, Rectal bleeding
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Pulmonary edema | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART II) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-2 , 19 85 , to 9-13 , 19 85 , that (I) (we) last
saw the deceased alive on 9-13 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Reginald O. Crosley | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Reginald O. Crosley | | | | | 22e. ADDRESS
Provident Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9/17/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H, Inc. | | | | | ADDRESS
4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR OF DEATHS
SEP 16 1985 | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

2

Primary column
secondary column
Tertiary column

17. 1-13-50

17. 1-13-50

276066

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--------------------------|---|-----------------------------------|--------------------------------------|----------------|-----|----------------|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| HELEN S. Smith | | | | | 9/24/85 | | | | 1 A.M. |
| 3 SEX | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | 7 UNDER 1 YEAR | | 8 UNDER 24 HRS | |
| Female | White | | 9 MONTH 2 DAY 1900 | | 85 YRS | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| New York | USA | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore City | NORTH CHARLES GEN'L Hosp 2121 | | HOUSEWIFE | | DOMESTIC | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| MD | BALT. | Randallstown | | | 8614 Bramble La - Apt 104 | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| MOSES | | SCHAFFER | | PEPI JONAS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| NO | | 213/14/4774 | | RONA HYMAN 3022 FAIRVIEW Rd 21207 | | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (b) Ischemic Cardiomyopathy | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

| | | | |
|--|--|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE) | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/23/85 to 9/24/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
| Marcos B. Galicia Jr., MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | SEP 26 1985 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | |
| MARCOS B. GALICIA Jr., MD | NORTH CHARLES GEN. Hospital | | |

| | | | |
|---|-------------------------------|------------------------------------|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) |
| BURIAL | 9-26-85 | HEBREW YOUNG MENS | WOODLAWN BALT. MD. |
| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| Hebrew Memorial F.H. 1100 REISTERSTOWN RD | OCT 1 1985 | Julian [Signature] | |

230275

269001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85 25550

1- FOR
STATE REGISTRAR John R. Smith

| | | | | | | | | | | | |
|---|--|---|--|---|----------------------------------|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN R. SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 22 85 | | 2b. HOUR
3 ³⁰ P.M. | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 29 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Southern Baltimore General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Tower Ford | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Baltimore | | | | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2843 Alabama Ave 21227 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN R. Smith | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FLORENCE V. MASSEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-12-5672 | | 17. INFORMANT
Luna G Smith | | | | ADDRESS
Same Same 13e | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Co of lung | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF
(c) Co of Stomach and Small Bowel | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive pulmonary disease

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION
9/1/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Choleliths, Small Bowel obstruction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31/85, 19 to 9/22/85, 19, that (I) (we) last saw the deceased alive on 9/21/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. Goldstein | | | | DEGREE | | 22c. DATE SIGNED
9/22/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JORGE E ANDERSON | | | | 22e. ADDRESS
3001 South Hemm St Balto Md | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Pauline Baptist Ch Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Johnson Co N.C. | |
|--|--|----------------------|--|--|--|---|--|

| | | | | | | | |
|---|--|--------------------------------------|--|--|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | ADDRESS
4001 Ritchie Hwy Balto Md | | 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
John R. Smith | |
|---|--|--------------------------------------|--|--|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 and file them in the 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

328001



WILSON
100% COTTON FIBER
MADE IN U.S.A.

259107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then place in the container. Pages 1 and 2 are to be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

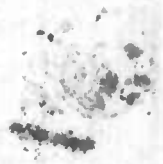
DHMM-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
<u>SMITH ANN L</u> Smith | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>09 09 85</u> | | | | | 2b. HOUR
<u>8 15</u> AM | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Negro</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>06 18 29</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>56</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Balto City</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Balto</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Sinai Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Principal</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Education</u> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>Md.</u> 13b. CITY OR TOWN <u>Balto</u> 13c. CITY OR TOWN <u>Pikesville</u> | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<u>7905 Crisford Plce</u> | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>William Gilmore</u> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Helen Cooper</u> | | | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<u>No</u> | | | | | 16b. SOCIAL SECURITY NO.
<u>214-28-6232</u> | | 17. INFORMANT
ADDRESS
<u>Charles Smith 7905 Crisford Pl.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic breast cancer</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Gastric ulcer</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>No</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>N/A</u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> NO | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 <u>85</u> | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<u>No</u> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK
<u>No</u> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)
<u>No</u> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> 19 <u>85</u> to <u>9/9</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>9/9</u> 19 <u>85</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Rhonda Fishel</u> MD | | | | | DEGREE
<u>MD</u> | | | 22c. DATE SIGNED
<u>9/9/85</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Rhonda Fishel</u> MD | | | | | 22e. ADDRESS
<u>Sinai Hosp of Baltimore</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>9-13-85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn</u> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Balto Md.</u> | | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Jas. A. Morton & Sons</u> ADDRESS
<u>1701 Laurens</u> | | | | | 25a. DATE REC'D. BY REGISTRAR
<u>SEP 11 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

MEDICAL CERTIFICATION

UNITED STATES
DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

| No. | | Date | | Description | | Amount | |
|-----|------|------|----|-------------|----|--------|----|
| 1 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 2 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 3 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 4 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 5 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 6 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 7 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 8 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 9 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 10 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 11 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 12 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 13 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 14 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 15 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 16 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 17 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 18 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 19 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 20 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 21 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 22 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 23 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 24 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 25 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 26 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 27 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 28 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 29 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 30 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 31 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 32 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 33 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 34 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 35 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 36 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 37 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 38 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 39 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 40 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 41 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 42 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 43 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 44 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 45 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 46 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 47 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 48 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 49 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 50 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 51 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 52 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 53 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 54 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 55 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 56 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 57 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 58 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 59 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 60 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 61 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 62 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 63 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 64 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 65 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 66 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 67 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 68 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 69 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 70 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 71 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 72 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 73 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 74 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 75 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 76 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 77 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 78 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 79 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 80 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 81 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 82 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 83 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 84 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 85 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 86 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 87 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 88 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 89 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 90 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 91 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 92 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 93 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 94 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 95 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 96 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 97 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 98 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 99 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |
| 100 | 1917 | 10 | 10 | 10 | 10 | 10 | 10 |



Printed at the Government Printing Office, Washington, D. C.

280067

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LOUISE SMITH | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-30-1985 | | 2b. HOUR
11:55AM | |
| 3 SEX
FEMALE | 4 RACE
BLACK | 5 DATE OF BIRTH
MONTH DAY YEAR
MAY 28, 1904 | 6 AGE (IN YEARS LAST BIRTHDAY)
81
YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
IF UNDER 24 HRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOME HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a STATE
MARYLAND | 13b COUNTY
N/A | 13c CITY OR TOWN
BALTIMORE | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM THOMAS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLA MILBURN | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
NO | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | 17 INFORMANT ADDRESS
21201..
KAREN WHEELER 841 W. LEXINGTON ST. | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) CA. OF THE STOMACH WITH METASTASIS
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 9-21 , 19 85 , to 9-30 , 19 85 , that (I) (we) last saw the deceased alive on 9-30 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Initials) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
<i>Walker Impagliatelli</i> | | DEGREE
MD. | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED
9/30/85 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
WALKER IMPAGLIATELLI M. D. | | 22e ADDRESS
CHURCH HOSPITAL CORP.
100 N. BROADWAY BALTO. MARYLAND 21231 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b DATE
10/4/85 | 23c NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | 23d LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
LEREOY O. DYETT 4600 LIB. HIGHTS. AVE. | | 25a DATE REC'D. BY REGISTRAR
OCT 2 1985 | 25b REGISTRAR'S SIGNATURE
<i>W. W. W. W.</i> | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5200B3

20% COTTON FIELD

DMO

FIELD



254127

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 5 3

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Mary Barbara Smith</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>September 7, 1985</i> | | 2b. HOUR
<i>5:30 P.M.</i> | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 28 06</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>79</i>
YRS MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Garden Village Nursing Home</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Housework</i> | | |
| 13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George Lipka</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Josephine</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>219-14-0431</i> | | 17. INFORMANT
ADDRESS
<i>Kenneth Smith 612 S. Montford Ave. 21224</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>—</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Reactive Depression; Gout; Nephrolithiasis; Alphanumeric Disease</i> | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>9/5/85</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>6/8/84</i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>6181 84 9/7/85</i> | | | | |
| 22a. I certify that (I) (the doctor) attended the deceased from <i>9/5/85</i> to <i>9/7/85</i> , that (I) (we) last saw the deceased alive on <i>9/5/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Albert B. Bradley</i> | | | DEGREE
<i>MD</i> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>9/9/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ALBERT B. BRADLEY, M.D.</i> | | | 22e. ADDRESS
<i>4900 BELAIR RD. BALTIMORE, MD. 21206</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>9-11-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Dulaney Valley Mem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Cockeysville, Baltimore Co., Md.</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Charles S. Zeiler & Son Inc.</i> | | | ADDRESS
<i>901 S. Conkling St.</i> | | | 25a. DATE REG'D. BY REGISTRAR
<i>SEP 9 1985</i> | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use as the burial-transit permit, this certificate must be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner may be substituted at any time.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be substituted at any time.

BP

VS1225



259195

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 5 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY L. SMITH | | | 2a. DATE OF DEATH
MONTH 07 , DAY 1985 | | 2b. HOUR
9:00 P.M. |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH 11 , DAY 11 , YEAR 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | IF UNDER 1 YEAR
MONTHS 00 , DAYS 00 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOME HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST Charlie , MIDDLE Sheppard , LAST Creasy | | | 15. MOTHER'S MAIDEN NAME
FIRST Creasy , MIDDLE Creasy , LAST Creasy | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO (ES. NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
SHEILA SMITH 408 MADEIRA STREET | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ASYSTOLE
DUE TO, OR AS A CONSEQUENCE OF
(b) ISCHEMIC CARDIOMYOPATHY
DUE TO, OR AS A CONSEQUENCE OF
(c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
MINUTES
YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from SEPTEMBER 07, 1985 to SEPTEMBER 07, 1985 , and that (b) (my) opinion death occurred on the date and hour and from the causes stated above. (If (a) did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE
David H. Madoff DEGREE MD, PhD | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID H. MADEFF M.D., PhD | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY BALTO., MD. 21231 | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
9/14/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Zion Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | 23e. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME Michael A.H. | | 24b. ADDRESS
1101 E. NORTH AVENUE | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the death certificate must be notified at once.

228132



92814 10000 2000

WMD C/MNTA/HAL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 5 5 5
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | |
|---|---------------------------|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Melvin Leon Smith | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
9 6 19 85 | | 2b. HOUR
M
2:15A |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
July 16 1948 | 6. AGE (IN YEARS)
LAST BIRTHDAY
37 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 10. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Loader | | 12b. KIND OF BUSINESS OR INDUSTRY
Warehouse |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Pr. Geo's. | 13c. CITY OR TOWN
Palmer Park | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
7601 Greenleaf Road 20785 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William L. Smith, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise Farmer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
68-1974 | | 17. INFORMANT (Mother) ADDRESS
SEAT PLEASANT,
Louise Swift/7252 Joplin St. MD. 20743 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8120 IMMEDIATE CAUSE (a) Lacerated liver with complications
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
5:55xx 8 9 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
driver in auto/parked auto impact |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 295 & Rt. 175 A.A. Co., MD. |
| 22a. I certify that I took charge of the remains described above, held in death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith, M.D. | | TITLE (SPECIFY)
M.D. Acting Chief | | DATE SIGNED
9/6/85 |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS
111 Penn St. Balto. MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
9/11/85 | 23c. NAME OF CEMETERY OR CREMATORY
HARMONY CEMETERY | 23d. LOCATION
LANDOVER PR. GEO'S MARYLAND |
| 24. FUNERAL DIRECTOR
NAME
ROLLINS FUNERAL HOME, INC. | | ADDRESS
4335 HUNT PLACE, N.E. | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 |
| | | 25b. REGISTRAR'S SIGNATURE
John Swisher | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1941

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

Film g607 item 13b,
9/26/85 rja

REG. NO.

| | | | | | | | | | | | | |
|--|--|---|--|---|---------------|---|----------------------------------|--|-----------|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
MILBRY | | MIDDLE
T | LAST
SMITH | | 2a. DATE OF DEATH
MONTH
09 | | DAY
11 | YEAR
85 | 2b. HOUR
6:41 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH
Feb. 25, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 | | 7. IF UNDER 1 YEAR
MONTHS
09 | | 8. IF UNDER 24 HRS.
DAYS
11 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
FLA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
FLA | | 13b. COUNTY
Lake | | 13c. CITY OR TOWN
Leesburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1211 Bonaire Dr. 32748 | | | | |
| 14. FATHER'S NAME
FIRST
J. H. | | | | MIDDLE
Tompkins | | LAST
15. MOTHER'S MAIDEN NAME
FIRST
Selete | | MIDDLE
McCall | | LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
266 80 7332 | | 17. INFORMANT
Ivan Beyers, | | ADDRESS
Leesburg, FLA 32748 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>EXSANGUINATION</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
15 min | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>RIGHT VENTRICULAR LACERATION</u> | | | | | | | | | | 30 min | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>STERNAL DEHISCENCE</u> | | | | | | | | | | 1 DAY | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
8-26-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CORONARY ARTERY DISEASE | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 8-26-85 to 9-11-85, that (2) we last saw the deceased alive on 9-11-85 and that in my opinion death occurred on the date and hour and from the causes stated above, (3) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Alfred G. Gale</u> | | | | | | DEGREE | | 22c. DATE SIGNED
9-11-85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CASALE | | | | | | 22e. ADDRESS
JHH | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal-Burial | | 23b. DATE
9/12/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenwood Cem. | | 23d. LOCATION
CITY OR TOWN
Wildwood, | | COUNTY
FLA | | STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John A. Anderson</u> | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED AS NON-NEGOTIABLE PER MR. HENRY SMITH, MILBURY

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the undersigned physician and completely filled out. It should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should go to the funeral director, page 3 to the State Dept. of Health and Mental Hygiene prior to burial-transit removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the undersigned physician and completely filled out, it should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should go to the funeral director, page 3 to the State Dept. of Health and Mental Hygiene prior to burial-transit removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, no other traumatic event, the medical examiner must be notified at once.

2010-2011

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

263081

1 DECEASED NAME (TYPE OR PRINT) **MR MILTON SMITH** MIDDLE **SMITH** LAST **SMITH** **Sept. 10 1985** 7b HOUR **8 P.M.**

2 SEX **Male** 4 RACE **Black** 5 DATE OF BIRTH **1/24/24** 6 AGE (IN YEARS (LAST BIRTHDAY)) **61** 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Virginia** 7b CITIZEN OF WHAT COUNTRY? **U.S.A.** 8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH **Baltimore City** MD.

10 CITY OR TOWN OF DEATH **Baltimore** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Lutheran Hospital** 12a USUAL OCCUPATION (TYPE OF WORK OR BASIS OF WORKING LIFE) **Laundromat Att.** 12b. KIND OF BUSINESS OR INDUSTRY **—**

13a STATE **Md** 13b COUNTY **—** 13c CITY OR TOWN **Baltimore** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS / ZIP CODE **102 N. PACA ST / 21201**

14 FATHER'S NAME (FIRST MIDDLE LAST) **Unknown** 15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) **Unknown**

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **No** 16b SOCIAL SECURITY NO. **230-52-7271** 17 INFORMANT ADDRESS **Barbara Straker 102 N. Paca Street 21201**

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of Prostate - metastases

DUE TO, OR AS A CONSEQUENCE OF

(b)

Pulmonary Embolism

DUE TO, OR AS A CONSEQUENCE OF

(c)

ascending Cholangitis

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

old CVA

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT HOME ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on **9/9/85** 19 **85**
above, (I) (we) (did) (did not) see the body after death.

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b SIGNATURE

DEGREE

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION
CITY OR TOWN COUNTY STATE**Burial****9-13-85****Mt. Calvary Cemetery****Glen Burnie, A.A. Co., Md.**

24 MARSHALL W. Jones, Jr. 4101 Edmondson Ave 21229

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

SEP 17 1985**John Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. There please remove certain papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified of this.

262091

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. STATE REGISTRAR

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT G. SMITH | | | 2a. DATE OF DEATH
MONTH 9 DAY 11 YEAR 1985 2b. HOUR 8:15 AM | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH 11 DAY 22 YEAR 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST Phillip MIDDLE Smith LAST Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Harris LAST Harris | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
ADDRESS
Dorothy Snead 1506 Mountmoor Ct. 21217 | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Renal Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebrovascular accident | | 3 months |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertension | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **none**

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6-9-85 to 9-11-85 , that (1) (we) last saw the deceased alive on 6-10-85 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
A. McRanda | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
9-11-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. McRanda | 22e. ADDRESS
1010 St. Paul St. Bldg 2122 | | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-17-85 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Cem. | 23d. LOCATION
CITY OR TOWN Owings Mills COUNTY Maryland STATE |
| 24. FUNERAL DIRECTOR
NAME
Bailey-Douglass Funeral Home 1348 Calhoun St. | | 25a. DATE REC'D. BY REGISTRAR
SEP 17 1985 | |

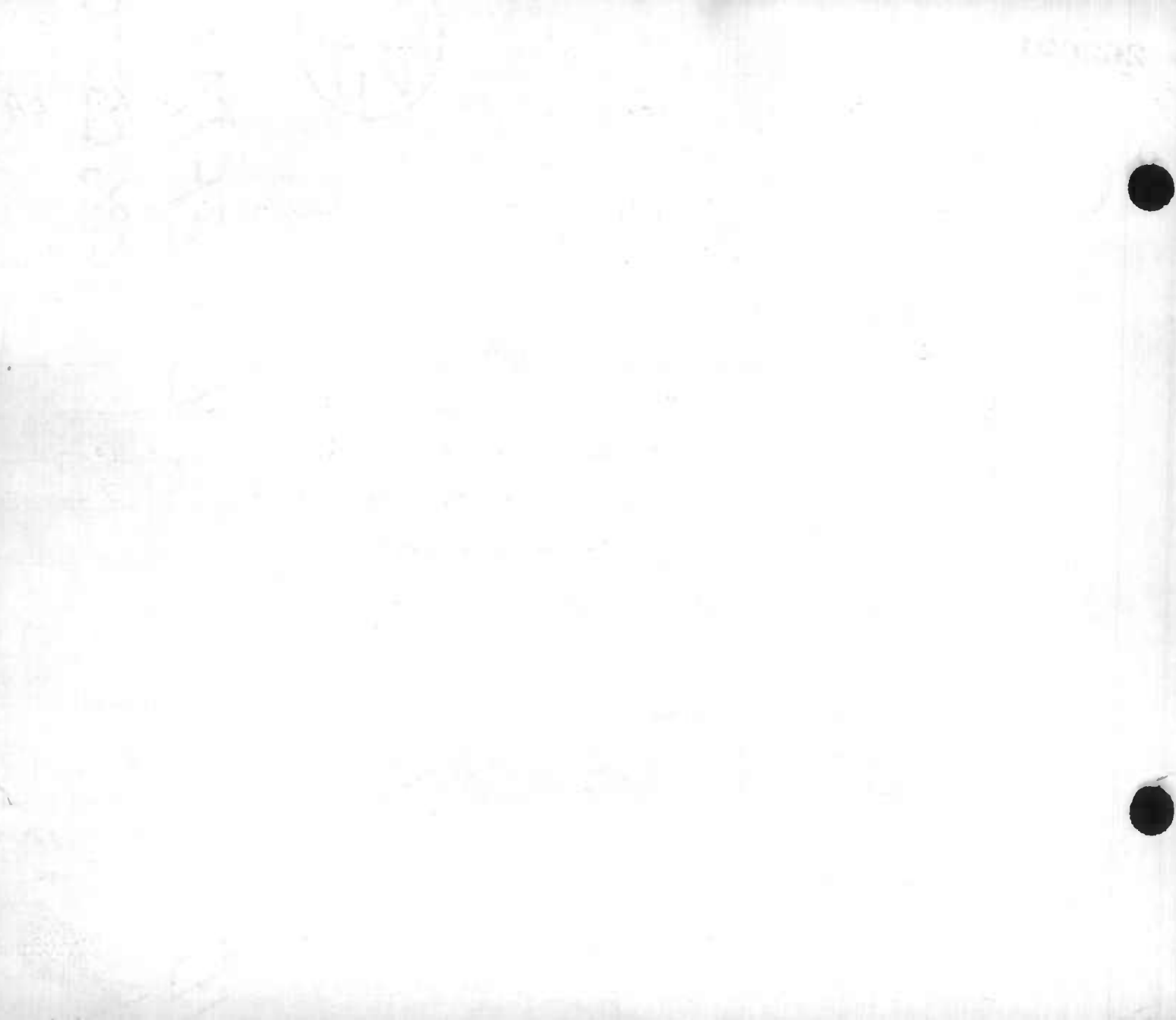
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100000



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

268057

| | | | |
|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST <u>ROONEY</u> MIDDLE <u>D</u> LAST <u>SMITH</u> | | 2a DATE OF DEATH MONTH <u>9</u> DAY <u>18</u> YEAR <u>85</u> 2b HOUR <u>1523 PM</u> | |
| 3 SEX
<u>Male</u> | 4 RACE
<u>Caucasian</u> | 5 DATE OF BIRTH
MONTH <u>9</u> DAY <u>16</u> YEAR <u>37</u> | 6 AGE (IN YEARS LAST BIRTHDAY)
<u>48</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | 7b CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
<u>BALTIMORE</u> City MD. |
| 10 CITY OR TOWN OF DEATH
<u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>University Hospital</u> | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired</u> 12b KIND OF BUSINESS OR INDUSTRY
<u>U.S. Govt.</u> | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>Maryland</u> 13b. COUNTY <u>A.A.</u> 13c. CITY OR TOWN <u>Glen Burnie</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE
<u>7949 Park West Drive 21061</u> | |
| 14 FATHER'S NAME
FIRST <u>Leroy</u> MIDDLE <u>Smith</u> LAST <u>Smith</u> | | 15 MOTHER'S MAIDEN NAME
FIRST <u>Eva</u> MIDDLE <u>Carr</u> LAST <u>Carr</u> | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
<u>No</u> | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>216-34-2666</u> | 17 INFORMANT
ADDRESS
<u>Glen Burnie, Maryland 21061</u>
<u>Joan Smith 7949 Park West Drive</u> | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
15-20 min.

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) SMALL CELL CARCINOMA Right Lung

3 years.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|--|---|---|---|
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 <u>85</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> 19 <u>85</u> to <u>9/18</u> 19 <u>85</u> , that (I) (we) last
saw the deceased alive on <u>9/18</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | |
| 23a SIGNATURE
<u>P. Kennedy</u> | | DEGREE | 22c. DATE SIGNED
<u>9/18/85</u> |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>KENNEDY.</u> | | 22e. ADDRESS
<u>UMCC</u> | |

| | | | |
|--|-----------------------------|---|---|
| 23a BURIAL, CREMATION, REMOVAL
(SEE INSTRUCTIONS)
<u>Cremation</u> | 23b. DATE
<u>9/20/85</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Westview Crematory</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Catonsville Balto. Md.</u> |
| 24 FUNERAL DIRECTOR
NAME
<u>Raymond C. Fink Glen Burnie, Md. 21061</u> | | 25. DATE REC'D. BY REGISTRAR
<u>SEP 23 1985</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by the State Dept. of Health and Mental Hygiene.

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Smith

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Marshall

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 6 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Vivian Smith | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9/30/85 | | | 2b. HOUR
8:25AM | |
| 3 SEX
Female | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8/24/09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Pimlico Manor | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MD | | 13b. COUNTY
N/A | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILL RAYFIELD | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLEN MASON | | 13e. STREET ADDRESS / ZIP CODE
512 MT. Holley St. 21229 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
224-18-2658 | | 17. INFORMANT
RICHARD SMITH | | ADDRESS
512 MT. HOLLY ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (the hospital) attended the deceased from 5/12, 19 84, to 9/30, 19 85, that (we) lost (saw the deceased) on 9/12, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
(Signature) | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9-30-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Arthur M. Lebson, M.D. | | | | 22e. ADDRESS
3640 Fords Lane 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
10-4-85 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
BROWN/THOMPSON F.H. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 9 1985 | | 25b. REGISTRAR'S SIGNATURE
(Signature) | |
| ADDRESS
1913 W. BALTIMORE ST. | | | | | | | |

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MEDICAL CERTIFICATION

2
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

260053

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 6 1

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALFRED A. S. SNEAD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 03, 1985 | | | 2b. HOUR
8:44pm | | | | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 22, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY
Unknown | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
NONE | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
755 W. Lexington St. #1001 21201 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Parker | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie Brown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNKNOWN | | | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
ADDRESS
Brown, Nellie - Daughter 755 W. Lexington St. #1001 21201 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(b) Underlying Cardiac Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Sick Sinus Syndrome
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
49 mins | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a.
Squamous Cell Carcinoma of the Right Lung, Hypertension | | | | | | | | | | |
| 19a. DATE OF OPERATION
September 3, 1985 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
HOARSENESS | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 21, 1985 to September 3, 1985 , that (I) (we) lost
saw the deceased Sept. 3, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
John P. Delaney M.D. | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
September 3, 1985 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN P. DELANEY M.D. | | | | | | 22e. ADDRESS
22 S. Greene St. Baltimore, MD 21201 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(BY)
Burial | | | 23b. DATE
9/10/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Tree | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
E. L. Phillips 172 N. Mount St. | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
COLLECTION
RECEIVED



266102

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10-3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1, 2, 3, 4, AND 5 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25562

| | | | | | |
|--|------------------|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ida A. Snowden | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
9/ 14/ 19 85 | | 2b. HOUR
M
2:08
P M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 9 25 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
60 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3908 Gelston Dr. 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lee Taylor | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-20-6555 | | 17. INFORMANT
Cecelia Collins | |
| 17. ADDRESS
2711 W. Garrison Blvd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
M.D. Assistant | | DATE SIGNED
9/18/85 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/19/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H, Inc. West | | ADDRESS
4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

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BP

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(VR A15 ME (5))

SECTIONS

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20% COTTON

266018

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|---|--|---|--|---|--------------------|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Thomas W Snyder | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9-14-85 | | 2b. HOUR
7:55 p | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 25 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Plumber | | 12b. KIND OF BUSINESS OR INDUSTRY
Plumbing | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
129 S. Loudon Ave. 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Snyder | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Virginia McDonald | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-01-4862 | | 17. INFORMANT
ADDRESS
Virginia Russ 2027 Deering Ave. 21230 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE CECUM
DUE TO, OR AS A CONSEQUENCE OF
(b) WITH METASTASES TO THE LIVER
DUE TO, OR AS A CONSEQUENCE OF
(c) CARCINOMA OF THE LUNG. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1978 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CARCINOMA OF THE RECTUM | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Michael E. Pelcjo | | | | DEGREE
M | | | | 22c. DATE SIGNED
9/15/85 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael E. Pelcjo | | | | 22e. ADDRESS
St. Agnes Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
21229
SEP 19 1985 | | 25b. REGISTRAR'S SIGNATURE
F. Davidson Hande | | | | | | | |

MEDICAL CERTIFICATION

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ADOLPH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 3, 1985 | | | 2b. HOUR
12:30
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 14 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY
MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Insulation Estimator | | 12b. KIND OF BUSINESS OR INDUSTRY
Building | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
1003 Vanderwood Rd. Catonsville, Md. 21228 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley Sokolowski | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jean Chalecki | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korean 140-22-7418 | | 17. INFORMANT
ADDRESS
Rosemarie Sokolowski Same as 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 HOUR | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) ACUTE MYOCARDIAL INFARCTION | | | | | | | | 3 weeks | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) CORONARY ARTERY DISEASE | | | | | | | | 20 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) this hospital attended the deceased from August 17, 1985 to September 3, 1985 , that (I) (we) last saw the deceased alive on September 3, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R. Roubenoff MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
9/3/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R ROUBENOFF | | | | 22e. ADDRESS
600 N. WOLFE STREET BALTO. MD. 21205
JOHNS HOPKINS HOSPITAL 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
9/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Md. | | |
| 24. FUNERAL DIRECTOR
NAME
1630 Edmondson Ave. Catonsville, Md. 21228
Leroy M. & Russell C. Witzke Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | | 25b. REGISTRAR'S SIGNATURE
John Edmondson | |

28182

ARON COTTON FIBER

CHIEF JIM BOND



254061

Items 18-22a 11/7/85 mth F#609

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25563

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|-----------------------------|--|--------------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| CARRIE | | M. | | SOMERS | | | | 9 | | 5 | | 19 | | 85 | | | | 6:52 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Female | | White | | Mar. 13, 1933 | | 52 YRS. | | | | 9 | | 5 | | 19 | | 85 | | A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| S. Carolina | | USA | | | | Baltimore City | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | 1325 Cooksie St. Balto. Md. | | Housewife | | 21230 | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1325 Cooksie St. Balto. Md. | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| John H. Brown | | Lila Mae Jeffcoat | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 250-48-5721 | | Mr. Robert R. Somers, Same as above | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| (b) <u>Theophylline intoxication</u> | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| Arteriosclerotic cardiovascular disease & chronic obstructive pulmonary disease | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | subject ingested drugs | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | | | |
| Home | | Home | | 1325 Cooksie Street Baltimore City, Md. | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | Assistant | | 9-5-85 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | | | |
| Cremation | | 9/9/1985 | | Security Process Inc. | | Catonsville, Balto. Co. Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| McCully Funeral Home, 130 E. Fort Ave. 21201 | | SEP 9 1985 | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))

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CMO

WINTER

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Carrie Spangler | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 19 85 | | 2b. HOUR
8:00 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 16 17 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5525 Patrick Henry Drive | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13b. STREET ADDRESS
5525 Patrick Henry Dr. | | 13c. CITY OR TOWN
Baltimore | | 13d. STATE
Maryland | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nelson Craft | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Jane Webb | | 16. SOCIAL SECURITY NO.
217-38-3048 | |
| 17. INFORMANT
ADDRESS
Carrie J. Spangler 5525 Patrick Henry Dr. Balto. Md. 21225 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC MIXED MESODERMAL SARCOMA-LIVER
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mos
10 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 11-7 19 84 , to 9-19 19 85 , that (I) (we) last saw the deceased alive on 9-11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
William P. McGuire | | DEGREE
MD | | 22c. DATE SIGNED
9-20-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William P. McGuire, M.D. | | 22e. ADDRESS
JOHNS HOPKINS ONCOLOGY CENTER | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9-20-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk Baltimore | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD. | | 24. FUNERAL DIRECTOR
ADDRESS
McCully Funeral Home 437 E. Patapsco Ave. Balto. Md. 21201 | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 24 1985 | | 25b. REGISTRAR'S SIGNATURE
Gilda Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove carbon papers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the funeral director must be notified at once.

BP

220023



254108

FOR
1- STATE REGISTRAR 9-13-85 D.W.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25567
REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|--|--|----------------------------|--|--------------------------------------|--|---|--|------|--|------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2c. HOUR | |
| Minnie Spell | | | | | | | | XX | | 9-2 | | 19 | | 85 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Female | Black | 5/17/14 | | 71 | | YRS. | | | | 9-4 | | 19 | | 85 | | 12:30 a.m. | |
| 7a. BIRTHPLACE (STATE OR TERRITORY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Greenland | | USA | | WIDOWED | | | | | | Baltimore City, | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 1803 W. Lexington Street | | Housewife | | None | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md | | | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1803 W. Lexington street | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Fred Hule | | Barth | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | | | | | | |
| no | | 239-12-1826 | | | | | | | | | | | | | | | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Hypertensive Cardiovascular Disease | | | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | | | (b) | | | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | Assistant | | 9-4-85 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | 8/7/85 | | Mt Zion Cemetery | | Baltimore | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| William L. McGowan | | | | 3201 W. Holt | | SEP 9 1985 | | John Davidson-Randall | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORGONE PAGE 5. REMAINING PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91,

20% COTTON FIBRE

DAVID WATKINS



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|------------------------------------|--|---|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James SPICER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
September 28, 1985 | | 2b. HOUR
8:45 A M | | | | | | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8/21/21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11 W. 20th St. Apt 5K 21218 | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Clarence Spicer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Roxanna Spicer | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO.
218-14-5403 | | 17. INFORMANT
Mary Spicer | | ADDRESS
11 W. 20th St. Apt 5K 21218 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomegaly
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Arterioloephrosclerosis | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 28, 1985 to September 28, 1985 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 28, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23a. SIGNATURE
<i>Harry M. Harris</i> | | | | | | DEGREE
M.D. | | | 23c. DATE SIGNED
9/29/85 | | | | | | |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)
HARRY, HARRIS MD. | | | | | | 25a. ADDRESS
MGH MARYLAND GENERAL HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
10/1/85 | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansdowne A.A. Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Chas.A.Rice FSPA | | | | | | ADDRESS
1300 Eutaw Place. | | | 25a. DATE REC'D. BY REGISTRAR
OCT 9 1985 | | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

BP



287017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Page 3 should be filed in by the funeral director, page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

101012



WILLIAM J. HARRIS
RABBIT MOTION & CO.

WILLIAM J. HARRIS

WILLIAM J. HARRIS

WILLIAM J. HARRIS

WILLIAM J. HARRIS

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT)
BABY BOY SQUIRES | | 2a. DATE OF DEATH
9 9 29 85 | | 2b. HOUR
9:05 P.M. | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH 9 DAY 28 YEAR 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS 1 MONTH 17 DAYS 3.0 | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY of MD | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 13a. STATE
MD | | 13b. COUNTY
BALT | | 13c. CITY OR TOWN
BALT | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SQUIRES | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PREMATURITY</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>PRESUMED IVH</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/29 AM</u> 19 <u>85</u> , to <u>9/29 PM</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/29 AM</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>John O'Reilly</u> | | | | 22c. DATE SIGNED
9/29/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John O'Reilly | | | | 22e. ADDRESS
Univ. of Md Hosp Dept Ped | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
10/3/85 | | 23c. NAME OF CEMETERY OR CREMATORY | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | 23d. LOCATION
CITY OR TOWN
BALTO. | | 23e. STATE
MD. | |
| 25a. DATE REC'D. BY REGISTRAR
OCT 9 1985 | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

DHMH - 16 60M 7/84
(VRA 15, 4)

DHMH - 16 60M 7/84
(VRA 15, 4)

RECEIVED
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 5 7 0
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Martin P. Stachowski | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 5 85 | | 2b. HOUR
7:45 AM | |
| 3 SEX
Male | 4 RACE
Caucasian | 5 DATE OF BIRTH
MONTH DAY YEAR
3-9-1904 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81 yrs. | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Baker | | 12b. KIND OF BUSINESS OR INDUSTRY
Rices Bakery |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Md. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Martin Stachowski | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maryann Unk | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
215-10-7605 | | 17 INFORMANT
ADDRESS
21213 Dolores Stachowski 3622 Elmora Avenue | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) gastrointestinal bleeding
DUE TO, OR AS A CONSEQUENCE OF
(b) arterio-venous malformations
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 9/3 19 85 to 9/5 19 85 , that (we) last saw the deceased alive on 9/5 19 85 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael J. Fisher | | | | 22c. DATE SIGNED
9/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael J. Fisher | | | | 22e. ADDRESS
Mercy Hospital Baltimore Md | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9-7-85 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem. | |
| 23d. LOCATION
CITY OR TOWN
Balto, Md. | | 23e. COUNTY
BALTO. | | 23f. STATE
MD. | |
| 24 FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | |
| 25b. REGISTRAR'S SIGNATURE
James Harrison Hande | | | | | |

MEDICAL CERTIFICATION

9
9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11335

20% COTTON FIBER

WINDMILL BRAND



263165

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 5 7 1

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN B STADLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 12 85 | | 2b. HOUR
11:11 AM |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 23, 1907 | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
President | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Florida | 13b. COUNTY
Dade | 13c. CITY OR TOWN
Coral Gables | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13. STREET ADDRESS & ZIP CODE
3272 Riviera Dr 33134 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John L. Stadler | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Angelina Houser | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
261-26-7724 | 17. INFORMANT (Wife)
Lucille Rose Stadler | | ADDRESS
Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>SEVERE OBSTRUCTIVE LUNG DISEASE</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hour
2 hours
3 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>CONGESTIVE HEART FAILURE MYOCARDIAL ISCHEMIA</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> , 19 <u>85</u> , to <u>9-12</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9-12</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Kenneth J. Holroyd</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
<u>9-12-85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>KENNETH J. HOLROYD</u> | | 22e. ADDRESS
<u>JOHNS HOPKINS HOSPITAL
BALTIMORE MD 21205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
<u>9/16/85</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn Cem.</u> | 23d. LOCATION
CITY OR TOWN COUNTY
<u>Miami Dade Florida</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>E. Barnes</u>
<u>Fleming Funeral Service</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>SEP 18 1985</u> | 25b. REGISTRAR'S SIGNATURE
<u>Lelia Davidson-Randall</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, and 4 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
<i>Myrtle E. Stanley</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>September 5, 1985</i> | | | | 2b. HOUR
M
<i>AM</i> | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>5-17-1906</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>79</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Balto. Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>4609 Mary Avenue-21206</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Home Maker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | |
|---|-------------|---|---|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE
<i>Md.</i> | 13b. COUNTY | 13c. CITY OR TOWN
<i>Balto.</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Henry Pines</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Alice</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>212-07-8469</i> | |
| 17. INFORMANT ADDRESS
<i>Mr. Alfred H. Inners - 1605 Jeffers Rd. 21204</i> | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>POSSIBLE ACUTE MYOCARDIAL</i>
DUE TO, OR AS A CONSEQUENCE OF <i>INFARCTION</i>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

| | | | |
|--|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (don't) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>9-9-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gardens of Faith Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Balto. Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>John C. Miller Inc. - 6415 Belair Rd. - 21206</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>SEP 9 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25573 | |
|--|-------------------------|---|--|---|------------------|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EDWIN Elvin STEELE | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
<input checked="" type="checkbox"/> 9-12-85
<input type="checkbox"/> 19 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
May 1, 1947 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
38 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9-12-85
19 | | 2d. HOUR
11:20
M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1822 Swansea Road 21239 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eddie Steele | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillie Barnett | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
215-56-4942 | | 17. INFORMANT ADDRESS
Mr. William B. Garland 8404 Arroyo Place | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Neck injury
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MIN. MONTH DAY YEAR
1000 P.M. 9/12 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject fell down stairs | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home (cellar stairs) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1822 Swansea Rd. Balto., Md. 21239 | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
9-13-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Sept. 16, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 16 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Lilia Davidson-Randall</i> | | | |

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May 1, 1970

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 25574

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY D. STEELE | | 2a. DATE OF DEATH
MONTH 9 DAY 2 YEAR 85 | | 2b. HOUR
0330 M. |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH 5 DAY 19 YEAR 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WYMAN PARK HEALTH SYSTEM | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
TOWSON | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
212-16-3482
212163482 | | 17. INFORMANT
ADDRESS
21201
David Mock-1st Nat. Bank of Md. 25 S. Chas. St. |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) PNEUMONIA AND CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) - | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

FUNGICEMIA, METASTATIC COLON CARCINOMA, CORONARY ARTERY DISEASE

| | | | |
|--|---|--|---|
| 19a. DATE OF OPERATION
8/19/85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
OBSTRUCTING LEFT COLON TUMOR | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF SAVER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 8/6 , 19 85 , to 9/2 , 19 85 , that (we) last
saw the deceased alive on 9/2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (do) view the body after death. | | | |
| 22b. SIGNATURE
Peter Wallick | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
9/2/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER WALLICK M.D. | | 22e. ADDRESS
3301 WYMAN PARK DRIVE, BALTIMORE, MD 21218 | |

| | | | |
|---|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9-4-85 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Balto. Md. |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

MEDICAL CERTIFICATION

BP

031325



256044

ITEM NUMBER 13e PER-PH.CALL

STATE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE REGISTRAR 9-16-85 D.W.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
VICTORIA B. STEVARS | | | 2a. DATE OF DEATH MONTH DAY YEAR
09 07 85 | | 2b. HOUR
M |
| 3. SEX
FEMALE | 4. RACE
CAUC. | 5. DATE OF BIRTH
MONTH DAY YEAR
07-27-38 | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2617 FORKWAY | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
— | | 12b. KIND OF BUSINESS OR INDUSTRY
— |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
BALTO | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
VICTOR TOPORZYCKI | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VICTORIA CZARNECKI | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
— | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
— | | 17. INFORMANT
ADDRESS
PATRICIA 2617 FORKWAY | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **metastatic adenocarcinoma of**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Lung**

DUE TO, OR AS A CONSEQUENCE OF

(c) **—**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**months**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **—**

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from August , 19 85 , to — , 19 — , that (I) (we) last saw the deceased alive on Aug , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Steven P. Schutman MD | DEGREE
MD | 22c. DATE SIGNED
9/10/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven P. Schutman MD | 22e. ADDRESS
601 N. Broadway Bldg 2120 | | |

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
BURIAL | 23b. DATE
9/10/85 | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD |
| 24. FUNERAL DIRECTOR
NAME
KACZOROWSKI FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | |
| ADDRESS
3525 FLEET ST. | | REGISTRAR'S SIGNATURE
Julia Harrison-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



1947 FEBRUARY

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1947 FEBRUARY

266065

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 3 SEX | | 4 RACE | |
| OSCAR W. STEVENS | | male | | black | |
| 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 MONTHS | |
| 9 MONTH 9 DAY 1920 | | 65 YRS | | 17 85 | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | 10 CITY OR TOWN OF DEATH | |
| BALTIMORE CITY | | BALTIMORE CITY | | BALTIMORE | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| VETERANS ADMINISTRATION MEDICAL CENTER | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md | | | | Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) | |
| John Stevens | | Nan Cutler | | Yes | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH | |
| 215127547 | | Mary Stanton 4015 Lewiston Avenue VAMC 3900 LOCH RAVEN BLVD BALTO, MD 21218 | | Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 9-10-85 | | Embolization for bleeding duodenal ulcer | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| SEPTEMBER 7, 1985, to SEPTEMBER 17, 1985, that (we) lost | | Edward Richman | | 9-18-85 | |
| saw the deceased alive on SEPTEMBER 17, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (not) view the body after death. | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| | | Edward Richman M.D. | | 3900 Loch Raven Blvd 21218 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/20/85 | | Garrison Forest Vet | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| William C. March F/H 4300 Wabash Avenue | | SEPT 23 1985 | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) fulminant Hepatitis, Peritonitis, ARDS
DUE TO, OR AS A CONSEQUENCE OF (c) Kidney Failure, Duodenal Ulcer

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) Alcoholic liver disease

19a. DATE OF OPERATION: 9-10-85
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Embolization for bleeding duodenal ulcer
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. MONTH DAY YEAR: P.M. 19
21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE ☐ AT WORK NOT WHILE ☐ AT WORK
21e. PLACE OF INJURY: (AT HOME STREET FACTORY, OFFICE FARM, ETC.)
21f. LOCATION: CITY OR TOWN COUNTY STATE
22a. I certify that (this hospital) attended the deceased from SEPTEMBER 7, 1985, to SEPTEMBER 17, 1985, that (we) lost the deceased alive on SEPTEMBER 17, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (not) view the body after death.
22b. SIGNATURE: Edward Richman
22c. DATE SIGNED: 9-18-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Edward Richman M.D.
22e. ADDRESS: 3900 Loch Raven Blvd 21218

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 9/20/85
23c. NAME OF CEMETERY OR CREMATORY: Garrison Forest Vet
23d. LOCATION: CITY OR TOWN COUNTY STATE: Owings Mills Md
24. FUNERAL DIRECTOR: NAME ADDRESS: William C. March F/H 4300 Wabash Avenue
25a. DATE REC'D. BY REGISTRAR: SEPT 23 1985
25b. REGISTRAR'S SIGNATURE: [Signature]

20% COTTON 1986

WATFORD

WATFORD



20% COTTON 1986

259197

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25577
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|--|------------------|---|---|---|------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
Wilhelmina
(Wilhemina) Stevenson | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
9 9 1985 | | 7b. HOUR
M
5:35P
M | |
| 3 SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6 21 07 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
78 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 9 1985 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2128 Orleans Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William T. Waters | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie White | | 13e. STREET ADDRESS
2128 Orleans Street 21205 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Edward L. Cottman 2128 Orleans St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell, M.D. | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED
9/10/85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS
111 Penn St. Balto. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
9/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C March F/H Inc. 1101 E North Ave | | 25a. DATE REC'D BY REGISTRAR
SEP 13 1985 | | 25b. REGISTRAR'S SIGNATURE
John M. ... | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IT IS THE DUTY OF THE REGISTRAR TO DELIVER THIS CERTIFICATE TO THE FUNERAL DIRECTOR. THE REGISTRAR SHALL BE FILED WITHIN 24 HOURS OF DEATH. THE REGISTRAR SHALL BE FILED WITHIN 24 HOURS OF DEATH. THE REGISTRAR SHALL BE FILED WITHIN 24 HOURS OF DEATH.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

1000



1000



20% COTTON STREETS

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN EXAMINER'S OFFICE

BP

DHMH - 16 60M 7/84
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY ELIZABETH STEWART | | | 2a DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 29, 1985 | | 2b HOUR
05:01 AM |
| 3 SEX
Female | 4 RACE
NEGRO ID | 5 DATE OF BIRTH
MONTH DAY YEAR
Sept. 17, 1916 | | 6 AGE (IN YEARS LAST BIRTHDAY)
69 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeper | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
Md. | 13b COUNTY | 13c CITY OR TOWN
Balto. | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE
1506 Bradford Ave. 21213 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
ELLISOD SCRUGGS | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZABETH WRIGHT | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-20-7104 | | 17 INFORMANT
ADDRESS
Mamie SCRUGGS 2042 E. Hoffman St. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (1) this hospital attended the deceased from 9/29 19 85 to 9/29 19 85, that (1) we last saw the deceased alive on 9/29 19 85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
M. G. Threlkeld | | DEGREE
MD | | 22c DATE SIGNED
2/22/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
M. G. Threlkeld | | 22e ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b DATE
10-4-85 | 23c NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Annapolis County Md. | |
| 24 FUNERAL DIRECTOR
NAME
Calvin B. SCRUGGS | | ADDRESS
1412 E. Preston St. | | 25a DATE REC'D. BY REGISTRAR
SEP 30 1985 | |
| | | | | 25b REGISTRAR'S SIGNATURE
John Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN EXAMINER'S OFFICE

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RAYMOND B. STEWARD Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
SEPTEMBER 26, 1985 | | | 2b. HOUR
A
12:42 | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 2, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Postal Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Government | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
221 Melvin Ave 21228 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Steward | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Genevieve Taylor | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No - | |
| 16b. SOCIAL SECURITY NO.
? | | 17. INFORMANT
Gloria Steward | | 17. ADDRESS
Cooksville, Md. | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Status post coronary artery bypass resection of left ventricular aneurysm</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour
12 hours
36 hours | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Previous myocardial infarctions, Congestive Heart Disease - Failure</u> | | | | | | | |
| 19a. DATE OF OPERATION
9/24/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Atherosclerotic coronary vascular disease. | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>85</u> , to <u>9/26</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>9/26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
G. Michael Meyer | | DEGREE
MD | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Michael Meyer | | 22e. ADDRESS
600 N. WOLFE ST. BALTO. MD. 21205
Johns Hopkins Hospital, Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE) | | 23b. DATE
10-1-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Bushy Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonville Howard Md. | |
| 24. FUNERAL DIRECTOR
NAME
Harry W. Knight | | ADDRESS
Lykerville, Md. | | 25a. DATE REC'D. BY REGISTRAR
OCT 1 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed (yes or no) by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy parts. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be signed by a physician.

STEWART, RAYMOND
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 5 8 0
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM F. STINCHCOMB Sr. | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept. 28, 1985 | | 2b. HOUR
1:27AM | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 03 1896 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOME HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR AGENT OR WORKING (FE))
CARPENTER | |
| 12b. KIND OF BUSINESS OR INDUSTRY
HOUSING | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | |
| 13b. COUNTY
--- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2909 E. MONUMENT ST. 21205 | | 14. FATHER'S NAME
MIDDLE LAST
ASHBY F. STINCHCOMB | | | |
| 15. MOTHER'S MAIDEN NAME
MIDDLE
MARY CALVERT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
YES | | | |
| 16b. SOCIAL SECURITY NO.
217038627 | | 17. INFORMANT
ADDRESS
HELEN STINCHCOMB 2909 E. MONUMENT ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute Myocardial Infraction
And acute Renal Failure | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Cancer of Liver | | | | | |
| 19a. DATE OF OPERATION
MX N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) XXXX attended the deceased from Sept 28, 19 85 to Sept 28, 19 85 , that (I) XXXX saw the deceased alive on Sept 28, 19 85 , and that in (my) XXXX opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) XXXX view the body after death. | | | | | |
| 22b. SIGNATURE
X [Signature] | | DEGREE
MD | | 22c. DATE SIGNED
X 9/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
X STUMPER KATZ | | 22e. ADDRESS
X 4940 Eastern Ave 21224 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
10/01/85 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BAITO. BALTO. MD. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
[Signature] 1211 Chesapeake Ave. | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 30 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

9
9

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a physician or a funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Mary J. Strejcek</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>September 11, 1985</i> | | | 2b. HOUR
<i>12:25 PM</i> | | | | |
| 3 SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>August 31, 1895</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>90</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Poland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>605 S. Belnord Ave.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Cigar Maker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<i>Md.</i> | | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>605 S. Belnord Ave. 21224</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Anthony Kulski</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Frances Novak</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No.</i> | | | 16b. SOCIAL SECURITY NO.
<i>215-05-6147A</i> | | 17. INFORMANT
ADDRESS
<i>Margaret Kulikowski 605 S. Belnord Ave.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cong. HRT Failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Old Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-12</i> 19 <i>83</i> , to <i>9-11</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>9-11</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Theodore Wyzulski MD</i> | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>9-13-85</i> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>T. T. WYZULSKI M.D.</i> | | | 22e. ADDRESS
<i>929 S CHESTER ST 21231</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | | | 23b. DATE
<i>9-14-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Stanislaus Cemetery Balto.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Balto. Md.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>John M. Weber & Sons Inc.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>SEP 13 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Wanda Davidson Handell</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed at office.



252102

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25582

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|-----------------|---|---|---|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Elmer Bruce Stuart | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
9 2 19 85 | | | 2b. HOUR
M | | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
Feb. 4, 1899 | 6 AGE (IN YEARS)
(LAST BIRTHDAY)
86 YRS. | 7 IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8 IF UNDER 24 HRS.
HOURS MIN. | 9 DATE PRONOUNCED DEAD
9 2 19 85 | 10 HOUR
4:15P
M | |
| 11 BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 12 CITIZEN OF WHAT COUNTRY?
USA | | 13 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 14 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 15 CITY OR TOWN OF DEATH
Baltimore | | 16 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
514 Cording Avenue | | | 17 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Tool & Die Maker | | 18 KIND OF BUSINESS OR INDUSTRY
Warner-Lambert | |
| 19 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Maryland | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e STREET ADDRESS
514 Cording Ave. | | 13f CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13g STREET ADDRESS
21212 | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
William H. Stuart | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 1 | | 17 INFORMANT
E. Bruce Stuart | | 18 ADDRESS
8920 Satyr Hill Rd.
Baltimore, Md. 21234 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<u>Margarita A. Korell</u> | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
9/3/85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn St. Balto.MD. | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
Sept. 6, 1985 | | 23c NAME OF CEMETERY OR CREMATORY
Govans Presbyterian | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | 25a DATE REC'D. BY REGISTRAR
SEP 4 1985 | | 25b REGISTRAR'S SIGNATURE | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

07/B4
25MBP
DHWH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

528105



Handwritten notes and markings, including a large 'X' and various illegible scribbles.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

270097

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|---|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Georgine Va Sunwalt | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 20 85 | | | 2b HOUR
6:24 PM | | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
2 1 09 | | 6 AGE (IN YEARS (LAST BIRTHDAY))
76 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9 CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 12 CITY OR TOWN OF DEATH
Maryland | | 13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 14 USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 15 KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | |
| 16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
17a STATE
Md. | | | | 17b CITY OR TOWN
Baltimore | | 17c INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18 STREET ADDRESS / ZIP CODE
5137 Wetheredsville Rd 21207 | |
| 19 FATHER'S NAME
FIRST MIDDLE LAST
Unknown Pilling | | | | 20 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | |
| 21 WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 22 SOCIAL SECURITY NO.
212-32-0400 | | 23 INFORMANT
ADDRESS
Mr. Charles E. Sunwalt Same as #13 | | | |
| 24 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolus
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
CARCINOMATOSIS | | | | | | | | | |
| 25a DATE OF OPERATION | | | 25b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 26a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 26b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 27a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 27b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 27c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 28a INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 28b PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 28c LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 29 I certify that (this hospital) attended the deceased from August 20 19 85 , to Sept 20 19 85 , that (we) last saw the deceased alive on Sept 20 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 30 SIGNATURE
Ben J. Minton M.D. | | | | | | 31 DEGREE
M.D. | | 32 DATE SIGNED | |
| 33 PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 34 ADDRESS | | | |
| 35 BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 36 DATE
9-21-85 | | 37 NAME OF CEMETERY OR CREMATORY
Security Process | | 38 LOCATION
CITY OR TOWN COUNTY STATE
Baltimore | | |
| 39 FUNERAL DIRECTOR
NAME ADDRESS
Cremation Society of Md. Catonsville | | | | | | 40 DATE REC'D. BY REGISTRAR
SEP 25 1985 | | 41 REGISTRAR'S SIGNATURE
[Signature] | |

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COLLECTION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED NAME
(Type or Print) Dorothy E. WITAKER SWANN | | | 2a. DATE OF DEATH
MONTH 9 DAY 16 YEAR 85 | | 2b. HOUR
M |
| 1. SEX
F. | 4. RACE
NEGRO | 5. DATE OF BIRTH
MONTH 8 DAY 25 YEAR 15 | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO.. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1391 LIMIT AVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Public School |
| 13a. STATE
MD. | 13b. COUNTY
BALTO | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1391 Limit Ave | |
| 14. FATHER'S NAME
FIRST LORENZO MIDDLE WHITAKER LAST WHITAKER | | 15. MOTHER'S MAIDEN NAME
FIRST MAUDE MIDDLE T. LAST WHITE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
514 20 5697 | | 17. INFORMANT
MELVIN C. SWANN Greensboro, N.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GI Blood - chemo
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
Metastatic Ca pancreas
DUE TO, OR AS A CONSEQUENCE OF
ly. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4mo |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION
4/19/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ca Pancreas | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1985 to 1985 , that (I) (we) last saw the deceased alive on 9/10 , 19 85 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael Levin | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/18/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael Levin | | 22e. ADDRESS
10807 Falls Rd | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9/20/85 | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | 23d. LOCATION
CITY OR TOWN COUNTY STATE
H.A. COUNTY MD. | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | |
| 24. FUNERAL DIRECTOR
NAME
LOCKS FUNERAL HOME | | ADDRESS
1304 N. Central | | 25b. REGISTRAR'S SIGNATURE
Michael Levin | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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274065

 FOR Film G608 item 3
 1- STATE REGISTRAR 10/7/85 rja

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

85 25585

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JEROME LEON SWEETS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 20 85 | | | 2b. HOUR
1300 M | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
03-11-41 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (COUNTRY)
BALTO. MD. | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE city MD. | | | | |
| 12. CITY OR TOWN OF DEATH
BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MIEMSS | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
2452 W. BALTIMORE ST. 21223 | |
| 14. FATHER'S NAME
- FIRST MIDDLE LAST
WILLIAM HOLIDAY | | | 15. MOTHER'S MAIDEN NAME
- FIRST MIDDLE LAST
ALICE SWEETS | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
UNKNOWN | | | | |
| 16a. SOCIAL SECURITY NO. | | | 17. INFORMANT
ISABELLE ALLEN | | | 17. ADDRESS
2452 W. BALTO. ST. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF
(b) HYPERTENSION
DUE TO, OR AS A CONSEQUENCE OF
(c) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 19 19 85 to SEPT 20 19 85 , that (I) (we) last saw the deceased alive on SEPT 20 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Charles D. Hanft MD | | | | | | 22c. DATE SIGNED
9-20-85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES D. HANFT MD | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | | | 23b. DATE
9-27-85 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEM. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | | | | 24. FUNERAL DIRECTOR
NAME ADDRESS
BROWN/THOMPSON F.H. 1913 W. BALTO. | | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 27 1985 | | | | | | 25b. REGISTRAR'S SIGNATURE
J. H. Davidson-Randall | | | | |

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

271002

100% COTTON

MADE IN U.S.A.

3

MALE

Black

Jerome A. Swartz

Baltimore

Baltimore, Maryland

263028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Charles W. Sykes III | | | 2a DATE OF DEATH
MONTH DAY YEAR
9-11-85 | | | 2b HOUR
12:15 P.M. | | | |
| 3 SEX
male | | 4 RACE
col | | 5 DATE OF BIRTH
MONTH DAY YEAR
3-9-1932 | | 6 AGE (IN YEARS LAST BIRTHDAY)
53 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore Md | | 9b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2358 McCulloh St | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Trackman | | 12b KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 13a STATE
Maryland | | | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
Charles W. Sykes | | | | 15 MOTHER'S MAIDEN NAME
Emma Wilson | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b SOCIAL SECURITY NO.
218-28-0001 | | 17 INFORMANT
Mrs. Gladious Sykes | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cancer of the PANCREAS
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
9 mos | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
small bowel obstruction | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (1) (the hospital) attended the deceased from July 3, 1985, to Sept 11, 1985, the (1) (last) saw the deceased alive on August 29, 1985, and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.) | | | | | | | | | |
| 22b SIGNATURE
James E. Haminigan MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
9-12-85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES E. HAMINIGAN | | | | 22e. ADDRESS
600N. WOLFE ST, BALT., MD. 21205 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
9-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | 23d LOCATION
BALTO. CO. MD | | | |
| 24 FUNERAL DIRECTOR
NAME
Joseph L. Russ | | | | ADDRESS
2222 W. North Ave. | | 25a DATE REC'D. BY HEALTH DEPT.
SEP 10 1985 | | 25b REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician must be notified at once.

2000

DMC 7 MAX 73111

NOTICE OF



249091

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | |
|--|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary C. Synan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Sept 2 1985 | | 2b. HOUR
4 (A.M.) | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 28, 1906 | | |
| 6 BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Phila., Penn. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
412 Montrose Avenue-21228 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John K. Yates | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma T. Kelly | | 17. INFORMANT
Mrs. Clare M. Mosmiller- Md. 21228 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
165-09-7328 | | 17. INFORMANT
Mrs. Clare M. Mosmiller- Md. 21228 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Artherosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Pneumonia | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR (A.M.) MONTH DAY YEAR
4 P.M. 5 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31 , 19 85 , to Sept 2 , 19 85 , that (I) (we) last saw the deceased alive on Sept. 2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Evan Selsky MD | | DEGREE | | 22c. DATE SIGNED
9/2/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Evan Selsky MD | | 22e. ADDRESS
Mercy Hospital
301 St. Paul Pl., Balto., Md. 21202 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery-Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Sterling Funeral Estate, P.A. | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |
| 26. ADDRESS
736 Edmondson Ave., Catonsville, Md. 21228. | | | | | | |

MEDICAL CERTIFICATION

779

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



100013

Handwritten notes and stamps are visible throughout the page, including a large '100013' in the center and various smaller markings and stamps.

266078

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85 25588
8456101- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|--|---|--|---|----------------------------|---|--|--|--|--|--|------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RANDALL, EARL SZEKELY | | | 2a. DATE OF DEATH
MONTH SEPTEMBER DAY 17 YEAR 85 | | 2b. HOUR
5:40 AM | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH October DAY 16 YEAR 1955 | | 6. AGE (IN YEARS LAST BIRTHDAY)
29 YRS | | 7. UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. UNDER 24 HRS.
HOURS 0 MIN. 0 | | | |
| 9. BIRTHPLACE
STATE OR FOREIGN COUNTRY
MARYLAND | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 13. CITY OR TOWN OF DEATH
BALTIMORE | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV OF MD Hosp | | | | 15. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PLANT MANAGER | | 16. KIND OF BUSINESS OR INDUSTRY
GAMES | | | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
17a. STATE MARYLAND 17b. COUNTY A. A. | | 18. CITY OR TOWN
GLEN BURNIE | | 19. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. STREET ADDRESS / ZIP CODE
131 LOUISE TERRACE 21061 | | | | | | | |
| 21. FATHER'S NAME
FIRST STEVEN MIDDLE M. LAST SZEKELY | | 22. MOTHER'S MAIDEN NAME
FIRST KATHRYN MIDDLE A. LAST PERKINS | | 23. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 24. SOCIAL SECURITY NO.
220.66.5499 | | 25. INFORMANT
NANCY C. SZEKELY (WIFE) | | 26. ADDRESS
SAME AS # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
9108 IMMEDIATE CAUSE (a) CARDIAC FAILURE | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) RESPIRATORY FAILURE (ARDS) 7 DAYS | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) NEAR DROWNING 9 DAYS | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.
CERVICAL SPINE FRACTURE - C6-7 LEVEL | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE OF INJURY
(STREET, CITY OR TOWN, COUNTY, STATE)
home | | 21c. HOW INJURY OCCURRED
SUBJECT DROVE INTO WATER 4-5 FT. DEPTH FOUND FLOATING IN POOL | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 8 19 85 to SEPT 17 19 85 that (I) (we) lost saw the deceased alive on SEPT 17 19 85 and that (I) (we) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Charles D. HANE | | 22c. DEGREE
M.D. | | 22d. APPROVED BY MEDICAL EXAMINER
MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22e. DATE SIGNED
9/17/85 | | | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES D. HANE | | 23b. ADDRESS
22 S. GREENE ST. | | | | | | | | | | | |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23d. DATE
SEPTEMBER 20, 1985 | | 23e. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23f. LOCATION
CITY OR TOWN BROOKLYN COUNTY A.A. STATE MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME SINGLETON FUNERAL HOME ADDRESS GLEN BURNIE, MD | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | | 25b. REGISTRAR'S SIGNATURE
John Burden | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be enrolled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

10-1-13

10-1-13

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10-1-13

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVING.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

DHMH - 17
(VR A15 ME (5))

| | | | | | | | | | | | |
|--|---------|--|--------|---|---|---|--------------------------------------|-----------------------------------|-------------------------|---|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2. DATE KNOWN OF DEATH | | DATE ESTI-MATED | MONTH | DAY | YEAR | 2b. HOUR |
| BELLA | | | | SZUPP | | | <input checked="" type="checkbox"/> | 9 | 2 | 85 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED DEAD | | 10. HOUR |
| MALE | WHITE | JAN. 26, 1925 | | 60 YRS. | MONTHS | | DAYS | | 9-2-85 | | 8:43A |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| HUNGARY | | U.S.A. | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 1137 E. Baltimore Street | | | | SEAMAN | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MARYLAND | | | | BALTIMORE CITY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1107 BALTIMORE STREET 21202 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| UNKNOWN | | | | UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| NO | | 141-32-6193 | | HARRY LUNDEBERG SCHOOL KEN CONKLIN, PINEY POINT, MARYLAND 20674 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | |
| | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Margarita A. Korell, M.D. | | | | Assistant | | | | 9-2-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn Street | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| BURIAL | | 9/5/85 | | SEAFARERS HAVEN | | CITY OR TOWN COUNTY STATE | | | | | |
| VALLEY LEE, ST. MARY'S, MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS | | | | | | SEP 10 1985 | | John Davidson-Randall | | | |
| EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD. | | | | | | | | | | | |



280087

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be attached for use on the burial/transit permit. Then please remove carbon papers. Page 1 of 4 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 9 0

| | | | |
|---|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Roosevelt Tabb</i> | | 2. DATE OF DEATH MONTH DAY YEAR
<i>Sept 26 1985</i> | |
| 3. SEX
<i>MALE</i> | 4. RACE
<i>B</i> | 5. DATE OF BIRTH MONTH DAY YEAR
<i>MAY 9 1909</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>76</i> YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>VIRGINIA</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTO. CITY</i> MD. |
| 10. CITY OR TOWN OF DEATH
<i>Balto</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>LUTHERAN</i> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Longshoreman</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Dock</i> |
| 13a. STATE
<i>MD</i> | 13b. COUNTY
<i>BALTO</i> | 13c. CITY OR TOWN
<i>BALTO</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Benjamin Tabb</i> | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Rosa Trowel</i> | 16. SOCIAL SECURITY NO.
<i>218 033 074</i> | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE BRANCH) (IF YES, GIVE WAR OR DATES)
<i>No</i> | 17b. INFORMANT
<i>Julia Tabb</i> | 17c. ADDRESS
<i>801 N DUKELAND ST</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a))
<i>SEPSIS</i>
DUE TO, OR AS A CONSEQUENCE OF
(b)
<i>PNEUMONIA</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>L. C. CHERO</i> | DEGREE | 22c. DATE SIGNED
<i>9/26/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>LUTHERAN L. CHERO</i> | 22e. ADDRESS
<i>LUTHERAN HOSPITAL</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | 23b. DATE
<i>9-30-85</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Jerusalem B.Cem.</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Charles City Va.</i> |
| 24. FUNERAL DIRECTOR NAME
<i>Bailey-Douglass</i> | ADDRESS
<i>1348 N. Calhoun St.</i> | 25a. DATE REC'D. BY REGISTRAR
<i>OCT 3 1985</i> | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> |

BP

780025



260057

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 5 5 9 1

| | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Eleanor G. Tadder</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>9-5-85</i> | | | 2b. HOUR
<i>2:50 P.M.</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12-07-88</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>82</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY)
<i>AUSTRIA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City, MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Sinai Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OR WORKING LIFE)
<i>TREASURER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>CLOTHING CO.</i> | |
| 13a. STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>BALTIMORE</i> | | 13c. CITY OR TOWN
<i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>UNKNOWN</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>MARIE WALDMAN</i> | | | 16. SOCIAL SECURITY NO.
<i>21215</i> | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | | 17b. SOCIAL SECURITY NO.
<i>21215</i> | | | 17c. STREET ADDRESS / ZIP CODE
<i>3818 FORDS LA., APT. 101</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>
<i>9110</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <i>Asphyxiation 2° to aspirated blood.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Massive hemorrhage into Trachea</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>30 min</i>
<i>35 min</i>
<i>35 min</i> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
<i>Sepsis; Probable intraabdominal abscess</i> | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>8/22/85</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Perforated Sigmoid Diverticulum</i> | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<i>P.M.</i> | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/22, 1985</i> to <i>9/5, 1985</i> , that (I) (we) last saw the deceased alive on <i>9/5, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>J. P. Knud-Hansen, MD</i> | | | DEGREE
<i>MD</i> | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> HOUSE STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>9/5/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>J. P. Knud-Hansen, MD</i> | | | 22e. ADDRESS
<i>SINAI HOSP. - BALTO., MD</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>SEPT. 8, 1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>BALTIMORE HEBREW</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>REISTERSTOWN BALTO. MD</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>SOL LEVINSON & BROS., INC.</i> | | | ADDRESS
<i>6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | 25a. DATE REC'D. BY REGISTRAR
<i>SEP 13 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

1
2
9
79

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

5-10-68

FIBER

DOOR



20%

DOOR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

277851
3

| | | | | | | | | | | | | | | | | |
|---|--|--|---|--|---|---|--|---|--|---|-----------------------------------|---|---|-----------------------|---|---|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 5 | 2 | 5 | 5 | 9 | 2 |
| FOR
1. STATE 10-7-85 D.W.
REGISTRAR | | | | | | | | | | 85 | | | | | | |
| 277851 | | | | | | | | | | 277851 | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Robert L Talbert | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 26 85 | | | | 2b. HOUR
noon
M | | |
| 3. SEX
Male | | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 18 19 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
66
YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 74 HRS
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ. Md. Hosp | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unknown | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2011 W. BROOK AVE 21217 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Talbert | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lula Hankerson | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
215-14-872 | | | 17. INFORMANT
PR | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/2 hour | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Paraplegia secondary to metastatic lung CA | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
Sept 26 1985 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Paraplegia | | | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 26 1985, to Sept 26 1985 that (I) (we) last saw the deceased alive on Sept 26 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Norman Herskowitz MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
9/26/85 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Norman Herskowitz | | | 22e. ADDRESS
Univ. Md. Hospital, 22 Green St | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK IF)
Burial | | | 23b. DATE
10.1.85 | | 23c. NAME OF CEMETERY OR CREMATORY
King MEM. PK. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
EL. Phillips 1781-27 N. MONROE | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 1 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital to attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the above pages and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18, check any injury, or other traumatic event, or other traumatic event, or other traumatic event.

63

2680756

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 occurs any injury, or other traumatic event, the medical examiner should be contacted.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 25593

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EDNA TALLIE | | | 2a. DATE OF DEATH
MONTH 9 DAY 16 YEAR 85 2b. HOUR 9:35 PM | | |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH 8 DAY 31 YEAR 20 | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD 21222 | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | | 13b. CITY OR TOWN
Glen Burnie | | 13c. STREET ADDRESS / ZIP CODE
6214 Eldridge Rd. 21061 |
| 14. FATHER'S NAME
FIRST Julius MIDDLE Westbrook LAST Westbrook | | | 15. MOTHER'S MAIDEN NAME
FIRST Willie MIDDLE Leager LAST Leager | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
220-14-0756 | | 17. INFORMANT
Elder James Tallie 6210 Eldridge Rd? 21061 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain death 2° to cerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Atrial Fibrillation, chronic
DUE TO, OR AS A CONSEQUENCE OF
(c) cardiopulmonary arrest
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Hx of previous strokes, Hx of Hypertension. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/15 , 19 85 , to 9/16 , 19 85 , that (I) (we) last saw the deceased alive on 9/16 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Mukesh Luhar | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/17/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mukesh Luhar MD | | | 22e. ADDRESS
1576 Merritt Blvd, Suite 14A
Baltimore, MD 21222 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
9/21/85 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn A.A. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Chas.A.Rice FSPA 1300 Eutaw Place | | | 25a. DATE REC'D. BY REGISTRAR
SEP 23 1985 | | |

256040

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25594 | |
|---|------------------|---|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Carmelo Carmelo Taormaino | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
9 7 19 85 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 3 1898 | 6. AGE (IN YEARS)
LAST BIRTHDAY
88 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 8. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 7 19 85 | | 2d. HOUR
9 05 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3310 Fleet Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Shoemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Emp. | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3310 Fleet St. 21224 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown Taormino | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown Unkn own | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | (IF YES, GIVE WAR OR DATES)
WWI | | 16b. SOCIAL SECURITY NO.
212 28 8357 | | 17. INFORMANT
ADDRESS
Sarah Taormina 3310 Fleet St. 21224 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u>
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Thomas D. Smith</i> | | | | TITLE (SPECIFY)
M.D. Acting Chief | | | | DATE SIGNED
9/8/85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn St. Balto. MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Sept 11 '85 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville St. VA | | | |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler, Inc. | | | | ADDRESS
21231 1901 Eastern Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1985 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

MEDICAL CERTIFICATION



UNITED STATES

22014 101100 KO

270019

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 9 5

REG. NO.

| | | | | | |
|--|---|---|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARK A. TATE | | | 2a. DATE OF DEATH MONTH DAY YEAR
SEPT. 21, 1985 | | 2b. HOUR
10:00AM |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 2 60 | | 6. AGE (IN YEARS LAST BIRTHDAY)
24 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 23 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Maryland | | | 13b. CITY OR TOWN
Baltimore | 13c. STREET ADDRESS / ZIP CODE
121 E. Cherry Lane 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Don J. Tate | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie McCormick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-60-4923 | | 17. INFORMANT ADDRESS
Annie Tate 121 East Cherry Lane | |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c.
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pulmonary Edema</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>AIDS</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
8 Minutes
12 Hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a
<u>Pulmonary Abscesses, P. carinii Hypoxemia Esophagitis, AFB/MAI, CMV</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>AUG 26</u> , 19 <u>85</u> , to <u>Sept 21</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Sept 21</u> , 19 <u>1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
David R. Brown | | DEGREE | | 22c. DATE SIGNED
9/21/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID R. BROWN | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
CREMATION | | 23b. DATE
9/24/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR
SEP 25 1985 | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Hendall | | | | | |

250013

COTTON FIBER



Handwritten text, possibly a date or reference number, including "2014".

Handwritten text, possibly a signature or name, including "J. J. J.".

Handwritten text, possibly a date or reference number, including "2014".

Handwritten text, possibly a signature or name, including "J. J. J.".

Handwritten text, possibly a signature or name, including "J. J. J.".

266010

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HENRY PAUL TAYLOR | | | 2a. DATE OF DEATH MONTH DAY YEAR
9 14 1985 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
8 10 1914 | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5414 PERDUE AVENUE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FOREMAN | 12b. KIND OF BUSINESS OR INDUSTRY
BETH STEEL | |

| | | | | | | |
|------------------------|--|--|-------------|--------------------------------|---|--|
| 13a. STATE
MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3536 CARRIAGE HILL CIRCLE, 21133 |
|------------------------|--|--|-------------|--------------------------------|---|--|

| | |
|---|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY W. TAYLOR | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PEARL JAMES |
|---|--|

| | | |
|---|---|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | 17. INFORMANT
ADDRESS
CHARLES H. TAYLOR, 709 FERN VALLEY CIRCLE |
|---|---|---|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Dist Cell Carcinoma of lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|------------------------|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|---|---|

| | | |
|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|--|--|--|

| | | |
|--|--|---|
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
|--|--|---|

| | |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Fall</u> , 19 <u>84</u> , to <u>Sept 14</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Aug 20</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
|---|--|

| | | | |
|--|--------------|--|-----------------------------|
| 22b. SIGNATURE
<u>Davis M. Hahn</u> | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
9/17/85 |
|--|--------------|--|-----------------------------|

| | |
|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Davis M. Hahn | 22e. ADDRESS
5801 Loch Raven Blvd 21239 |
|--|--|

| | | | |
|--|------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9-20-1985 | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE COUNTY |
|--|------------------------|---|--|

| | | |
|--|--|--|
| 24. FUNERAL HOME OR
NAME ADDRESS
NUTTER & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PARKWAY, BALTO., MD 21216 | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> |
|--|--|--|

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

500000

100% COTTON FIBRE
MADE IN
INDIA



Handwritten text at the bottom of the page, including a date and a signature.

270014

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 5 5 9 7

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Susie A. Taylor | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 21 85 | | 2b. HOUR
10 ⁵⁷ AM | | | | |
| 3 SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 08 13 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GENERAL HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
James Russell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosetta Russell | | 13e. STREET ADDRESS / ZIP CODE
3012 LaRue Square East 21225 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unknown | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-34-7502 | | 17. INFORMANT ADDRESS
East
William Anderson 3012 La Rue Square | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0
<u>Neuroleptic Malignant Syndrome.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-18</u> to <u>9-21</u> , that (I) (we) last saw the deceased alive on <u>9-21</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Kenneth L. Macinow M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>9/22/85</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Kenneth L. Macinow M.D.</u> | | | | 22e. ADDRESS
<u>15 E. Quadrangle b, Cross Keys S.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<u>BURIAL</u> | | 23b. DATE
<u>9/26/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Anne Arundel Co, Md.</u> | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Wm C March F/H Inc.</u> | | | | ADDRESS
<u>1101 E North Ave.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>SEP 25 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Wm Anderson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20% COTTON FIBER

CHIEFMAN BOW



250014



277040

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 9 8

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) THEODORE R. Taylor | | | 2a DATE OF DEATH
MONTH DAY YEAR
9 25 85 | | 2b HOUR
8 12 PM | | | | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
07 17 10 | | 6 AGE (IN YEARS LAST BIRTHDAY)
75 | | IF UNDER 1 YEAR
MONTHS DAYS
75 | | IF UNDER 24 HRS.
HOURS MIN.
75 | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
N.C. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Decker Hospital Center | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Trucker | | 12b KIND OF BUSINESS OR INDUSTRY
Freight Co. | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b STATE Md. 13c COUNTY Baltimore 13d CITY OR TOWN Baltimore 13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13f STREET ADDRESS / ZIP CODE
1300 E. Lanvale St. 21213 | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Isaac Taylor | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maggie Curtis | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b SOCIAL SECURITY NO.
218-036579 | | | | 17 INFORMANT ADDRESS
Benjamin Morton 4912 Challedon Rd. 21207 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 85 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 8-10-85 to 9-25-85 , that (I) (we) last saw the deceased alive on 9-25-85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
Wanda J. Clemmons MD | | | | | | DEGREE
MD | | 22c DATE SIGNED
9-26-85 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
WANDA J. Clemmons | | | | | | 22e ADDRESS
611 South Charles Street. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b DATE
9-30-85 | | 23c NAME OF CEMETERY OR CREMATORY
Probus Memorial Park | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Probus Md. | | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Randolph J. Collier 2431 E. Oliver St. | | | | | | 25a DATE REC'D. BY REGISTRAR
OCT 1 1985 | | 25b REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and family, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

9 22 22 8 3

Thompson R. Taylor

12 10 17 01 12 12

W.C. Bishop

Baltimore

no

Postman

12 12

Taylor

no

Postman

12 12

Taylor

9 22 22 8 3

9 22 22 8 3

259118

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 5 9 9

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ALICE INEZ TERRY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
8 29 1985 | | 2b. HOUR
M |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
6 26 1900 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ELLAVILLE, GA. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3243 Normount Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
General Griffin | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edna | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
217-05-1633-A | 17. INFORMANT ADDRESS
Lois T. Lee, 3243 Normount Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>severe anemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>chronic renal failure</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>6 mo.</u>
<u>5 yrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>NO</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (u) (this hospital) attended the deceased from <u>7/1</u> 19 <u>85</u> , to <u>8/29</u> 19 <u>85</u> , that (i) (we) last saw the deceased alive on <u>8/27</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>C D Kearney MD</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>CHRISTOPHER D. KEARNEY</u> | | 22e. ADDRESS
<u>700 WASH BLVD BAL MD 21230</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
9-03-1985 | 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNE ARUNDEL COUNTY | |
| 24. FUNERAL DIRECTOR
NUTTER & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PARKWAY | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 13 1985
25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and have them filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the doctor must be notified of cause.

BP

22118

CHIEF MAN DOWN

20% COTTON LEEB



SEP 13 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 5 6 0 0

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CLARENCE TERRY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
9 13 85 | | | 2b. HOUR
139 M | | | | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
07 05 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3603 BELLE AVE 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD John E. Terry | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ha | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
WWII | | 17. INFORMANT
ADDRESS
Lillian Terry 3603 Belle Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) METASTATIC CARCINOMA OF THE PROSTATE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13/85 to 9/13/85 , that (I) (we) last saw the deceased alive on 9/13/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Rebecca A Lee M.D. | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
REBECCA A LEE M.D. | | | | | 22e. ADDRESS
Provident Hosp. 2602 Liberty Hgts Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | 23b. DATE
9/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus B. C. Md. | | |
| 24. FUNERAL DIRECTOR
Charles A. Rice FSPA 1300 Eutaw Pl, | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 19 1985 | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |

MEDICAL CERTIFICATION

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it is to be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CLASSIFICATION

TYPE

NUMBER

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